NARCOTICS REGULATION

EXISTING methods of narcotics regulation have failed to stem the postwar tide of addiction. Police and hospital records indicate a sharp increase in the number of narcotics users since 1946.[1] Alarmingly, teen-agers account for a large proportion of these new addicts.[2] This apparent failure of the present regulatory pattern has aroused numerous attempts to find new solutions. The Senate Crime Committee, the New York Attorney General, and the New York Mayor's Committee on Narcotic Addiction recently held hear-

1. From 1946 through the first nine months of 1951, addicts among New York prison inmates increased from 628 to 1886, and the number sentenced on narcotics charges by New York courts rose from 281 to 1179. GOLDSTEIN, NARCOTICS, A REPORT BY THE ATTORNEY GENERAL TO THE LEGISLATURE OF THE STATE OF NEW YORK 10 (Legis. Doc. No. 27, 1952) (hereinafter cited as GOLDSTEIN, REPORT). Narcotics arrests in New York have tripled in the same period, *id.* at 19; and in Chicago arrests in 1950 were roughly 6 times the 1948 figure. *Hearings before Special Senate Committee to Investigate Organized Crime in Interstate Commerce*, 82d Cong., 1st Sess. pt. 14, p. 282 (1951) (hereinafter cited as *Crime Committee Hearings*). Arrests by the United States Bureau of Narcotics more than doubled between 1946 and 1950. *Hearings before Subcommittee of the Committee on Ways and Means on H.R. 3490 and H.R. 348*, 82d Cong., 1st Sess. 57 (1951) Admissions to the federal narcotic hospital at Lexington have risen, *Crime Committee Hearings* pt. 14, p. 131 (1951), as have admissions of teen-age addicts to Bellevue Hospital in New York. GOLDSTEIN, REPORT 49-50 (1952). Increased arrests and hospitalization may, however, be partly due to growing public awareness and stricter law enforcement.

The present growth of addiction reverses the trend established between 1917 and 1945. One index is the decline in military service rejections for addiction from 1 in 1500 in World War I to 1 in 10,000 in World War II. *Narcotic Drug Control* in INTERNATIONAL CONCILIATION 301, 305 (1948). The large number of addicts before World War I was probably due to the unrestricted sale of patent medicines with narcotic content prior to the passage of federal pure food and drug legislation. See NEW YORK CITY MAYOR'S COMMITTEE ON DRUG ADDICTION, REPORT OF STUDY ON DRUG ADDICTION AMONG TEENAGERS 6 (1951) (hereinafter cited as MAYOR'S COMMITTEE, REPORT).

Estimates of the total number of United States addicts vary greatly. See *id.* at 13-16 for estimates varying from 100,000 to 1,000,000. The Mayor's Committee calculates, on the basis of arrests of peddlers, that New York City alone has 90,000 addicts. *Id.* at 19.

2. The percentage of patients below the age of 21 at the federal narcotics hospital at Lexington, Ky., increased from 3% in 1946 to 18% in 1951. SEN. REP. No. 725, 82d Cong., 1st Sess. 27 (1951). For the first 9½ months of 1951 there were 340 admissions of teen-age addicts at Bellevue and Kings County Hospitals in New York as compared with a cumulative total of 85 in the preceding five years. NEW YORK CITY MAYOR'S COMMITTEE ON DRUG ADDITION, INTERIM REPORT, DRUG ADDICTION AMONG TEENAGERS 5 (1951) (hereinafter cited as MAYOR'S COMMITTEE, INTERIM REPORT). The number of addicts among juvenile prisoners in New York jumped from 19 in 1946 to 237 in 1951. GOLDSTEIN, REPORT 16. Arrests of teen-agers in Chicago for narcotics violations rose from 136 in 1948 to 1017 in 1950. *Crime Committee Hearings* pt. 14, p. 282. On the basis of testimony from teachers and police officials, the New York Attorney General estimates that 1 out of every 200 New York City high school students is a narcotics user. GOLDSTEIN, REPORT 35-40.

ings and proposed changes.[3] For the first time on all regulatory levels—international, national, and state—legislators and administrators are making a concerted effort to discover the nature of the entire narcotics problem and, thus, the basis for its solution.[4]

THE PROBLEM

The principal narcotic drugs are opium, cocaine (a coca leaf derivative), and marihuana (a hemp plant extract).[5] Aside from their addictive qualities, all fulfill important medical functions—chiefly as pain relievers.[6] Opium, the major addictive drug,[7] may be taken in three principal forms: morphine, heroin, or smoking opium. Opium smoking, while common in Asia, is rare in the United States.[8] Medically, morphine is the most commonly administered narcotic.[9] It is, therefore, used by those who become addicted through medical treatment and by purchases of drugs from doctors and pharmacists.[10] Most addicts, however, take heroin—probably over 95 percent of American addicts are heroin users.[11] The peddler prefers

3. See *Crime Committee Hearings* pt. 14; SEN. REP. No. 725, 82d Cong., 1st Sess. (1951); GOLDSTEIN, REPORT; MAYOR'S COMMITTEE, REPORT; MAYOR'S COMMITTEE, INTERIM REPORT.

4. In the past there have been attempts to solve specific narcotics problems at one level of regulation. See, *e.g.*, NEW YORK CITY MAYOR'S COMMITTEE ON MARIHUANA, THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK (1944). Until 1951, however, there were no attempts to make a comprehensive study of the problem and to simultaneously solve it on all three regulatory levels.

5. See BAILEY, THE ANTI-DRUG CAMPAIGN 4-8 (1935); Anselmino, *A.B.C. of Narcotic Drugs*, LEAGUE OF NATIONS OFFICIAL DOC. C.C.P. 44(I) (1931).

6. Opium has served as a pain reliever for nearly 6000 years. See MAYOR'S COMMITTEE, REPORT 2-6. Cocaine is used particularly for its anesthetic effect on the mucous membranes of the mouth and eye. However, the development of synthetic substitutes such as eucaine, novocaine, and butyn has greatly reduced its medical vogue. *Id.* at 8. Marihuana is useful for migraine headaches, spastic conditions, strychnine poisoning, depressive melancholia, and labor. See WALTON, MARIHUANA, AMERICA'S NEW PROBLEM DRUG 151-7 (1938). See also *The Indispensable Use of Narcotic Drugs*, 96 A.M.A.J. 856 (1931).

7. See 7 ENCYCLOPEDIA BRITANNICA 677 (14th ed. 1943). For methods of opium cultivation, see Anselmino, *A. B. C. of Narcotic Drugs*, LEAGUE OF NATIONS OFFICIAL DOC. C.C.P. 44(I), pp. 13-16 (1931).

8. For the relative unimportance of opium smoking in the United States, see TERRY & PELLENS, THE OPIUM PROBLEM 74 (1928). In China, on the other hand, there were 2,250,00 registered opium smokers in 1927. MAYOR'S COMMITTEE, REPORT 16.

9. Each year millions receive morphine pre-operatively and post-operatively. See *Crime Committee Hearings* pt. 14, p. 115.

10. See SEN. REP. No. 725, 82d Cong., 1st Sess. 29 (1951). For examples of addiction due to medical administration, see *Crime Committee Hearings* pt. 14, pp. 154, 167.

11. Exact figures are unavailable. The Senate Crime Committee found that the great majority of adult addicts and "practically all the younger group" use heroin. SEN. REP. No. 725, 82d Cong., 1st Sess. 29 (1951). Of 292 teen-age addicts treated at Bellevue Hospital in 1951, 289 used heroin. MAYOR'S COMMITTEE, INTERIM REPORT 31-2. In 1919,

heroin because of its easy dilutibility and its great euphoric effect.[12] Complementing these opium derivatives, scientists have developed powerful synthetics.[13] But, so far, addiction to synthetics has not posed as serious a problem as heroin addiction.[14]

People generally turn to narcotics to compensate for emotional insecurity and other personality defects; they wish to escape reality and responsibility.[15] By taking opium, the addict loses himself in pleasurable sensations and daydreams.[16] Cocaine provides stimulation with ecstatic but short-lived effects.[17] And marihuana smoking results in distortions of time and space accompanied

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96.5% of 7464 addicts registered at the New York City narcotic clinic took heroin. TERRY & PELLENS, THE OPIUM PROBLEM 473 (1928).

12. MAYOR'S COMMITTEE, REPORT 5. Heroin is about twice as potent as morphine, and its side effects are not as unpleasant. *Crime Committee Hearings* pt. 14, p. 140. The adulteration of heroin by peddlers sometimes exceeds 99%. BUREAU OF NARCOTICS, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1947, p. 13 (1948).

13. See Isbell, *The Newer Analgesic Drugs: Their Use and Abuse*, 29 ANN. INT. MED. 1003-12 (1948). See also *Narcotic Drug Control* in INTERNATIONAL CONCILIATION 301, 354 (1948). For a case study of the effects of a particularly potent synthetic, ketobemidone, see *Crime Committee Hearings* pt. 14, p. 121-3.

14. SEN. REP. No. 725, 82d Cong., 1st Sess. 29 (1951).

15. Dr. Reichard, working with patients at the federal narcotics hospital at Lexington, Kentucky, found that addicts are usually socially inadequate, immature persons who hide behind narcotics; that they are fleeing from psychological or physical discomfort. Reichard, *Addiction: Nature, Cause, Prevention, and Treatment*, 103 AM. J. PSYCHIATRY 721, 728 (1947). The New York City Mayor's Committee on Marihuana concluded that persons may turn to narcotics because of difficulty in making social contacts. NEW YORK CITY MAYOR'S COMMITTEE ON MARIHUANA, THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK 132 (1944). The medical officers in charge of the Public Health Service's narcotics treatment program find that the "vast majority of narcotic drug addicts are fundamentally emotionally immature childlike persons, who have never made a proper adaptation to the problems of living. . . . [They] find in morphine, much as the tired businessman finds in the preprandial cocktail, a means of return to 'normal.' This is a false situation which may be recognized by the tired businessman but is not recognized by the drug addict." VOGEL, ISBELL, & CHAPMAN, PRESENT STATUS OF NARCOTIC ADDICTION 6-8 (1948). See also SEN. REP. No. 725, 82d Cong., 1st Sess. 27 (1951); GOLDSTEIN, REPORT 52; *Crime Committee Hearings* pt. 14, p. 146. See note 19 *infra*.

16. The addict experiences a sensation of tingling, his stomach rumbles, and he has a feeling similar to sexual orgasm. Following this initial thrill, the addict goes "on the nod": in a half awake, half asleep condition, he may experience dreams which allow him to "take out his difficulties in fantasy." See testimony of Dr. H. Isbell, Director of Medical Research at the Lexington Narcotic Hospital, in *Crime Committee Hearings* pt. 14, p. 121. For a comprehensive bibliography on the effect of opiates see *Hearings before a Subcommittee of the Committee on Ways and Means on H.R. 3490 and H.R. 348*, 82d Cong., 1st Sess. 172-6 (1951).

17. Ecstatic sensations from cocaine are so pleasant that the typical addict will take repeated doses (of as much as one grain) at intervals of only five or ten minutes till his supply is exhausted. While some addicts sniff cocaine, most resort to intravenous injections. See *Crime Committee Hearings* pt. 14, pp. 41-2. For the historic development of cocaine addiction, see MAYOR'S COMMITTEE, REPORT 7-8.

by lightheadedness.[18] Maladjustments leading to addiction may vary anywhere from severe psychoses to simple anxiety states;[19] one clear insight into the causes of addiction is suggested by the fact that narcotics users generally come from slum, broken, or unhappy homes.[20] However, the causes of the recent rise in teen-age addiction may also lie elsewhere. Teen-age addicts, while frequently possessing inadequate personalities, seem also to be immature pleasure seekers following school or community narcotics fads.[21]

18. *Crime Committee Hearings* pt. 14, p. 142. Effects of marihuana smoking are mild, probably because of the difficulty of obtaining a high concentration of the drug as long as it is smoked. Asiatics concentrate marihuana in hashish, which is chewed and is far more potent. *Id.* at 119. Marihuana also leads to a lessening of inhibitions. See WILLIAMS, HIMMELSBACH, WIKLER, RUBLE, & LLOYD, STUDIES ON MARIHUANA AND PYRAHEXYL COMPOUND 23-4 (1946). For compilation of the various descriptions of effects of marihuana smoking, see WALTON, MARIHUANA, AMERICA'S NEW DRUG PROBLEM 55-150 (1938).

19. Dr. K. W. Chapman, Assistant Surgeon General of the Public Health Service (U.S.P.H.S.) in charge of narcotic hospitals, Dr. V. H. Vogel, medical officer in charge of the Lexington Narcotic Hospital, and Dr. H. Isbell, medical officer in charge of research at Lexington, find that addicts fall into four psychological groups. (1) Psychotics —who make up the smallest group—often have "borderline mental illness and sometimes frank mental illness." (2) Psychopathic persons—who make up the largest group—are usually "emotionally undeveloped aggressive hostile persons who take drugs merely for pleasure arising from the unconscious relief of inner tension." (3) Psychoneurotic persons take narcotics to gain relief from manifestations of their neurosis, such as anxiety. (4) There is a group with the characteristics of both psychoneurotic and psychopathic persons—those with severe dependency problems, emotionally immature adults, withdrawn schizoid types, and those suffering with "milder degrees of maladjustment and inadaptiveness to the complications of living." VOGEL, ISBELL, & CHAPMAN, PRESENT STATUS OF NARCOTIC ADDICTION 7-8 (1948). See also Felix, *Some Comments on the Psychopathology of Drug Addiction,* 23 MENT. HYG. 567 (1939); Felix, *An Appraisal of the Personality Types of the Addict,* 100 AM. J. PSYCH. 462 (1944); Kolb, *Types and Characteristics of Drug Addicts,* 9 MENT. HYG. 300 (1925). See note 15 *supra.*

20. The majority of youthful heroin addicts treated at the Lexington and Fort Worth Hospitals came from broken homes where one or both of the parents were absent. VOGEL, OUR YOUTH AND NARCOTICS 3 (1951). Likewise, Dr. K. W. Chapman, Assistant Chief, Division of Hospitals, U.S.P.H.S., testified that most persons treated for addiction by the Public Health Service are from marginal economic groups. GOLDSTEIN, REPORT 49. In 1951, two thirds of the patients under 21 and one-third of all patients at Lexington Hospital were Negroes. *Crime Committee Hearings* pt. 14, p. 132. Harlem seems to be the center for narcotics sales in New York. See GOLDSTEIN, REPORT 60-8. In Chicago narcotic sales are also concentrated in slum areas. *Crime Committee Hearings* pt. 14, p. 285. Most of the Negro addicts from the Maryland House of Correction who testified before the Senate Crime Committee were from broken homes, left school early, and had no money. *Id.* at 6.

21. Dr. Vogel states that while the majority of the teen-age addicts at Lexington come from broken homes and frequently have inadequate personalities, "they do not have emotional or personality difficulties sufficiently well organized to justify a diagnosis of a psychiatric or mental disorder." He believes that they are "pleasure seeking kids" who are following environmental fads, as did kids of an earlier era who thought it smart surreptitiously to smoke a cigarette or drink at parties. They "tragically found after using

In any case, it is clear that medical treatment with narcotics is rarely a cause of addiction.[22]

Contrary to popular misconception, narcotic addiction does not physically damage an individual nor render him dangerous. Rather, it perpetuates his psychological defects. Cocaine, it is true, if injected in sufficient quantity, may result in hallucinations, convulsions, and dangerous paranoid tendencies.[23] But its use is relatively rare. And cocaine addicts generally take heroin as an antidote before dangerous symptoms develop.[24] Marihuana may lead to violent tendencies, but only in a very small number of emotionally predisposed individuals.[25] In the most popular form of addiction—opiate—the addict is irresponsible,[26] but he is neither violent nor drunk.[27] Except for the discomfort of withdrawal, addiction is generally compatible with good physical

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heroin that they had a wildcat by the tail and couldn't let go." VOGEL, OUR YOUTH AND NARCOTICS 1, 3-4 (1951). See SEN. REP. No. 725, 82d Cong., 1st Sess. 28 (1951). For a discussion of teen-age addiction as a method of draft evasion, see *Crime Committee Hearings* pt. 14, pp. 226-7.

22. Less than 5% of the addicts at the Lexington Hospital became addicted as a result of medical administration of narcotics. This percentage is extremely small in the light of the millions who yearly receive morphine medically. Testimony of Dr. Isbell at *Crime Committee Hearings* pt. 14, p.115. It is claimed by some that medical treatment rarely leads to addiction because drugs do not cause euphoric effects in the emotionally stable person. See VOGEL, ISBELL, & CHAPMAN, PRESENT STATUS OF NARCOTIC ADDICTION 6 (1948); Kolb, *Pleasure and Deterioration from Narcotic Addiction*, 9 MENTAL HYGIENE 699, 723 (1925). For a dissenting view, see Felix, *An Appraisal of the Personality Types of the Addict*, 100 AM. J. PSYCH. 462 (1944).

23. See SEN. REP. No. 725, 82d Cong., 1st Sess. 24-5 (1951); *Crime Committee Hearings* pt. 14, pp. 116-18, 141-2. Cocaine addicts with paranoid delusions may misidentify and attack harmless individuals as imagined persecutors. For a graphic description of the effects of cocaine addiction, see *ibid.* (detailing experiments with cocaine administration on volunteers at the Lexington Hospital).

24. According to the Public Health Service, pure cocaine addiction is almost unknown in this country. When used, cocaine is ordinarily mixed with heroin in the form of a "speedball"—which is taken only intermittently "for a spree." *Id.* at 118, 145.

25. *Id.* at 119-120, 117, 142. A person about to commit a crime may take marihuana to allay his fear and anxiety. Reichard, *Some Myths About Marihuana*, Fed. Probation, Oct.-Dec., 1946, p. 18.

26. All the addict's interest is centered on obtaining and taking his drug. His social productivity is greatly decreased: he is usually in a dream state. *Crime Committee Hearings* pt. 14, p. 124. Clinical studies show a great reduction in physical and mental efficiency. See WILLIAMS, OBERST, & BROWN, A CYCLE OF MORPHINE ADDICTION, BIOLOGICAL AND PSYCHOLOGICAL STUDIES 41-2 (1946).

27. An addict who is "on the nod" can be aroused easily and will answer questions intelligently. He can walk about and very little loss of balance can be detected. Testimony of Dr. Isbell at *Crime Committee Hearings* pt. 14, pp. 120-1. Word response tests indicate that he will be much less disturbed psychologically by outside stimuli than a comparable non-addict. See WILLIAMS, OBERST, & BROWN, *op. cit. supra* note 26, at 34-40, 41-2. The sex urge is greatly decreased during addiction to any type of opiate. *Crime Committee Hearings* pt. 14, p. 289.

health,[28] and overdoses resulting in death are rare.[29] The real damage to the individual from narcotic addiction lies in its perpetuation of the unstable personality.[30] By resorting to flight from reality through narcotic addiction, the maladjusted individual never faces his life and responsibility squarely; narcotics become his constant crutch.

Once drug addiction begins, the addict's demand for narcotics tends to become constant, and the habit tends to spread. The emotionally unstable and the thrill seekers who turn to opiates are caught in the cycle of opiate addiction: (1) habituation, (2) tolerance, and (3) physical dependence. Habituation involves emotional reliance: the drug becomes an answer to all the addict's problems.[31] In time, the addict develops tolerance: increasing doses become necessary to recapture the earlier euphoric effects.[32] Finally, the addict is "hooked": he suffers nausea and other discomfort unless drugged.[33] At this stage he loses all sense of euphoria.[34] With heroin, the entire cycle may take less than a month.[35] In the process the addict "graduates" from sniffing to intravenous injections.[36] Unlike opium, the use of cocaine or marihuana does not itself lead to tolerance or physical dependence.[37] But use of mari-

28. While opiates cause temporary physiological changes in the nervous system, as yet no permanent damage has been discovered. Physical deterioration, if any, results from unclean habits in taking injections, and from using income for drugs instead of food and shelter. *Crime Committee Hearings* pt. 14, p. 146. For temporary physical effects of addiction, see WILLIAMS, OBERST, & BROWN, *op. cit. supra* note 26, at 1-25. Nor does marihuana cause any physical damage. *Crime Committee Hearings* pt. 14, p. 143. Prolonged use of cocaine, however, may prove physiologically harmful. Kolb, *Pleasure and Deterioration from Narcotic Addiction*, 9 MENTAL HYGIENE 699, 724 (1925); Reichard, *Narcotic Drug Addiction, A Symptom of Human Maladjustment*, 4 DISEASES OF NERV. SYS. 275, 279 (1943).

29. Deaths from narcotics account for less than 10% of deaths from all drugs. *Crime Committee Hearings* pt. 14, p. 146. However, narcotic deaths in New York City have increased from 11 in 1946 to 56 in 1950. MAYOR'S COMMITTEE, REPORT App. A.

30. Narcotic addiction stems frequently from psychological maladjustment. See notes 15, 19 *supra*. Studies indicate "that patients [addicts] who have made a marginal degree of emotional adjustment to life, and then have begun to use drugs, lose some of their normal adaptive patterns of adjustment. This regression in personality represents the greatest danger of drug addiction." VOGEL, ISBELL, & CHAPMAN, PRESENT STATUS OF NARCOTIC ADDICTION 6-8 (1948).

31. See note 15 *supra*.

32. See WILLIAMS, OBERST, & BROWN, *op. cit. supra* note 26, at 21-2; Reichard, *Narcotic Drug Addiction, supra* note 28.

33. See Reichard, *supra* note 28, at 276. For case studies of the effects of withdrawal (vomiting, sweating, aches, fever), see *Crime Committee Hearings* pt. 14, pp. 121-4. Withdrawal symptoms are uncomfortable but never fatal. *Id.* at 123.

34. Testimony of Dr. H. Isbell, *id.* at 145 (clinical observations at the Lexington Narcotic Hospital).

35. *Id.* at 289; GOLDSTEIN, REPORT 53.

36. *Crime Committee Hearings* pt. 14, pp. 143-4.

37. See NEW YORK CITY MAYOR'S COMMITTEE ON MARIHUANA, THE MARIHUANA PROBLEM IN THE CITY OF NEW YORK 132 (1944); *Crime Committee Hearings* pt. 14, p. 143. When the administration of cocaine is stopped, addicts have severe hangovers,

huana and cocaine frequently lead to opiate addiction and thus ultimately to physical dependence.[38] At the same time, the existence of one addict provides a medium through which peddlers may increase the demand for drugs by others. Testimony of teen-age addicts provides vivid illustration of the process: the arousing of curiosity by friends taking drugs, introduction to the drugs, and often a motivation to take the narcotics in order to "keep up" with the mores of the group.[39] Drug peddlers encourage the process by giving initial doses free.[40]

The heavy and constant demand for narcotics assures the economic well-being of a large and well organized bootlegging empire.[41] Because of the addicts' constancy of demand, a peddler is in a position to charge addicts every penny that they have. In Italy, the bootleggers' major source of supply, a kilo of heroin costs about $1500; in New York it may sell for $6,000.[42] The American wholesaler receiving the heroin in New York dilutes

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are weak, and eat poorly for several days. These symptoms, however, are toxic manifestations arising from the debauch rather than from the withdrawal and they are not relieved by additional injections of cocaine. *Id.* at 118, 288.

38. Without exception, the records of teen-age addicts at the Lexington Hospital show that they smoked marihuana more or less intermittently before becoming curious as to the effects of sniffing heroin. VOGEL, OUR YOUTH AND NARCOTICS 2 (1951). See also *Crime Committee Hearings* pt. 14, pp. 120, 143. Heroin addicts who appeared as witnesses before the Crime Committee and the New York Attorney General also showed a prior history of marihuana addiction. See *id.* at 13, 54-5, 72, 84, 100, 108, 171, 183, 189, 195, 203, 211, 253, 272, 295; GOLDSTEIN, REPORT 52, 54. For the relationship between cocaine and heroin addiction, see note 24 *supra*.

39. See SEN. REP. No. 725, 82d Cong., 1st Sess. 28 (1951). See also GOLDSTEIN, REPORT 89-90 (fifteen year old addict: "You hanging out with a crowd, one boy starts, everybody else follows"). Youthful witnesses before the Senate Crime Committee invariably testified that their friends introduced them to the habit. See *Crime Committee Hearings* pt. 14, pp. 14, 31, 55, 73, 75-6, 85, 87, 91, 94, 100, 105, 110, 162, 172, 189, 195, 204, 259, 295. Of 71 teen-age addicts appearing before the Chief Probation Officer of the Magistrates' Courts in New York City, each partook of drugs in company with from 5 to 15 other youngsters. GOLDSTEIN, REPORT 47-8. Investigations by the Chief Probation Officer of the Magistrates' Courts in New York City also show many cases where an addict, in order to get his own supply free, would make arrangements to get five or six other users. *Ibid.*

40. *Ibid.*

41. For a discussion of the operation of this bootlegging empire, see SEN. REP. No. 725, 82d Cong., 1st Sess. 30-3 (1951); *Crime Committee Hearings* pt. 14, pp. 352-4. The Senate Crime Committee and the Bureau of Narcotics believe that Lucky Luciano, deported narcotics trafficker, and Mafia control the illicit narcotic traffic. For smuggling operations by Luciano's alleged lieutenants, see *id.* at 344-8; SEN. REP. No. 725, 82d Cong., 1st Sess. 32 (1951).

42. These are the figures given by Mr. Charles Siragusa, undercover agent for the Bureau of Narcotics. *Crime Committee Hearings* pt. 14, pp. 349, 421. However, heroin is frequently smuggled in one-ounce packages by sailors. If bought by the ounce, the price will be higher. See *id.* at 421-3. Mr. G. W. Cunningham, the Deputy Commissioner of Narcotics, estimates that 75-90% of narcotics in the United States are funneled through New York. *Hearings, supra* note 16, at 72.

the kilo sufficiently to produce 135,000 capsules.[43] These he sells directly or through a network of agents to retailers throughout the country.[44] The large peddlers in each city jointly fix the retail prices.[45] These prices will vary from $1 to $15 per capsule. Variance in price occurs as a partial function of the risk of the illicit traffic and thus depends on the efficiency of a city's law enforcement officials or the severity of its courts.[46] For example, in Washington, D.C., a capsule costs $1; 30 miles away in Baltimore, where sentences are more severe, the price is $3.[47] In any event, by the time it reaches the consumer, the kilo's price has jumped from $1500 to approximately $200,000. The presence of substantial profit of course provides the *raison d'etre* for the existence of the illicit traffic.

The high price of narcotics coupled with a constant demand not only insures the bootleggers' prosperous life, but also produces serious social consequences of addiction. The average addict's weekly needs cost anywhere from $50 to $250.[48] Compelled to buy at these prices, the addict *must* raise the money to satisfy his craving. Consequently, the addict turns to money

43. This is based on figures given by Mr. G. W. Cunningham, Deputy Commissioner of Narcotics. *Crime Committee Hearings* pt. 14, p. 423. Mr. Cunningham based his calculations on an adulteration of 90%. However, the adulteration of seized heroin has sometimes exceeded 99%. BUREAU OF NARCOTICS, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1947, p. 13 (1948).

44. See SEN. REP. No. 725, 82d Cong., 1st Sess. 31 (1951).

45. For price fixing in New York City, see testimony of the Deputy Commissioner of Narcotics in *Crime Committee Hearings* pt. 14, p. 424. An agent of the Bureau of Narcotics testified that the large Buffalo narcotics dealers had a meeting in June, 1951, to organize a dope peddlers association. The contemplated function of the association was to assign districts to peddlers and to act as a centralized purchasing agency. GOLDSTEIN, REPORT 30.

46. Deputy Commissioner Cunningham reports the price as $15 in Memphis (where the penalties are most severe), $10 in Seattle, $3-4 in Texas, and $2 in New York. *Hearings, supra* note 16, at 72. However, addicts appearing before the Crime Committee testified that the price was only $1 in New York. *Crime Committee Hearings* pt. 14, pp. 86, 103, 205.

47. *Id.* at 36, 86, 102. This disparity in price, according to Deputy Commissioner Cunningham, is due to the fact that the minimum sentences for narcotics violators in Baltimore are greater than the maximum sentences in the District of Columbia. *Hearings, supra* note 16, at 75.

48. Addicts from Lexington hospital and from Maryland prisons appearing before the Senate Crime Committee were questioned about their narcotics expenditures. With no incentive to exaggerate, they testified as follows: $175 to $200 a week (Crime Committee Hearings pt. 14, p. 22); $15 to $25 a day (*id.* at 106); $12 a day (*id.* at 109); $25 to $30 a day (*id.* at 183); $10 to $30 a day (*id.* at 268); $30 to $80 a day (*id.* at 296); $9 a day (*id.* at 85); $75 a day (*id.* at 191); $20 a day (*id.* at 196); $40 to $50 a day (*id.* at 206); $40 to $50 a week (*id.* at 36); $3 to $9 a day (*id.* at 81). The New York Attorney General cited as typical of scores of interviews, the testimony of a 25-year old addict concerning narcotics expenditures of $200 a week. GOLDSTEIN, REPORT 57-8. On the basis of hospital records, Dr. Vogel estimates that addicts of high school age spend from $42 to $150 a week on drugs. VOGEL, OUR YOUTH AND NARCOTICS 4 (1951). Dr. Vogel's estimate is based on a price of $1 to $1.50 a capsule, which is far lower than prices in many cities. See notes 46 and 47 *supra*.

raising—although usually non-violent—crimes: mail theft, forgery, shoplifting, prostitution, confidence games, and peddling.[49] At the same time, the addict becomes useless to family, job, and society. His life's effort is directed toward procuring the money necessary to maintaining his habit. Narcotics users rarely have criminal records prior to addiction; but after addiction they resort to crime, and money illegally gained goes for drugs.[50] The perennial problem of narcotics regulation is the peculiar paradox that as the law is more strictly enforced against the peddler, the price rises and the incentive to crime and absorption of the addict in obtaining the drug increase.[51]

Attacks on the narcotics problem have been made at several levels. Efforts to wipe out the problem by constricting the world supply of narcotics have produced international agreements directed at production and manufacture of the drugs and their traffic into the United States. The federal and state governments have also attempted to strike at the supply by supervising import and traffic in medically necessary narcotics and penalizing participants in illicit traffic. At the same time, domestic controls attempt to reduce the demand for narcotics by dealing directly with addicts through penalties, rehabilitation, and educational measures. Finally, some effort has been made to solve the problem by legalizing and controlling narcotics usage in an attempt to eliminate the social consequences of the illicit narcotic market.

CONTROLLING THE SUPPLY

Pattern of International Control

Narcotic plants, with the exception of hemp, do not grow in the United States. Opium poppies are cultivated chiefly in Iran, India, Turkey, and Yugo-

49. The New York Attorney General found that addiction "almost inevitably" resulted in "crime and prostitution." See GOLDSTEIN, REPORT 53-9. See also SEN. REP. No. 725, 82d Cong., 1st Sess. 27-8 (1951). For testimony of addicts discussing their criminal activity see *Crime Committee Hearings* pt. 14, pp. 64 (larceny), 77 (theft), 81 (peddling), 95 (theft), 109 (prostitution), 159 (forging checks), 165 (peddling), 179 (theft), 189 (forgery and mail theft), 196-7 (mail theft, shoplifting), 206 (confidence games), 213 (forgery and mail theft), 260 (theft), 276-7 (prostitution, shoplifting, and mail theft), 296 (prostitution and confidence games). See N.Y. Times, May 9, 1951, p. 1, col. 2 (large increase in mail theft by addicts). See also RECKLESS, THE CRIME PROBLEM 276 *et seq.* (1951). The records of addicts at Lexington Hospital "show that the girls usually drift into prostitution as the only way to obtain the money necessary, and the boys drift into thievery of all kinds and gambling." VOGEL, OUR YOUTH AND NARCOTICS 4 (1951). Female addicts resort to prostitution in spite of the fact that addiction greatly decreases the sex urge. *Crime Committee Hearings* pt. 14, p. 289.

50. Dr. Vogel testified that the great majority of Lexington patients show no record of delinquency prior to addiction. After addiction, all sorts of "passive non-violent crime" is committed to support their habit. *Id.* at 135. A psychiatric study of adolescent addicts at Bellevue Hospital showed that "anti-social behavior occurs only when the youngsters desperately need money for the drug." GOLDSTEIN, REPORT 58-9.

51. The applicability of this paradox may be weakened, however, by the movement of addicts from high price to low price areas and by the inability of incarcerated peddlers to promote new customers.

slavia.[52] The poppies are transformed into heroin—the mainstay of the American addict—by licensed medical firms in Italy and by illicit factories in Turkey.[53] Adding to this supply, the Chinese communists have apparently reactivated former Japanese heroin factories in Manchuria.[54] Coca leaves originate chiefly in Peru and Bolivia.[55] Marihuana, only rarely extracted from domestic hemp, is principally Mexican in source.[56] Production and manufacture of narcotics in foreign countries exceeds by far the world's medical needs. From 1934 to 1937 the production of opium alone was ten times the amount necessary for medical needs.[57] Lack of supervision and control in the country of origin results in a surplus of narcotics which is obtained by criminal syndicates for importation into the United States.[58] And the high profits attaching to illicit trade in narcotics provides continuous stimulation for increased production. A logical answer to the narcotics problem is the exercise of complete control over the supply of narcotics. Since supply is international the scope of effective control must be international.

Efforts to control international supply and traffic have produced eight international narcotics conventions whose provisions are currently under the supervision of the United Nations. The Hague Convention of 1912 and the Geneva

52. *Hearings, supra* note 16, at 203; BUREAU OF NARCOTICS, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1950, p. 1 (1951). Principal sources of illicit raw opium smuggled into the United States are Iran, India, Turkey, Mexico and China in order of importance. Opium prepared for smoking purposes comes into this country chiefly from Mexico. *Id.* at 18-19.

53. *Crime Committee Hearings* pt. 14, p. 427; FEDERAL BUREAU OF NARCOTICS, A REVIEW OF INTERNATIONAL AND NATIONAL NARCOTIC CONTROLS 19 (1951).

54. See N.Y. Times, May 2, 1951, p. 17, col. 1 (Chinese heroin smuggled into Japan). See also *Crime Committee Hearings* pt. 14, pp. 429-30.

55. Coca leaves have also been successfully cultivated in Java, Formosa, and certain sections of Africa. See MAYOR'S COMMITTEE, REPORT 7.

56. Mexican marihuanna is used in preference to the domestic variety because of its superior quality and because of the effective control over the production of American hemp. See *Crime Committee Hearings* pt. 14, pp. 426-7.

57. MAYOR'S COMMITTEE, INTERIM REPORT 30 (based on figures reported by the League of Nations). Conditions do not seem to have improved. In 1950, for example, 333 tons of raw opium "disappeared" from Iran. This is more than 30 times the amount of illicit opium seized by authorities throughout the world in that year. N.Y. Times, Jan. 9, 1952, p. 11, col. 6.

58. Thus in 1950 the rate of Italian heroin production was about 200 kilos yearly. Italy's medicinal needs for both heroin and morphine ranged between 25 and 50 kilos. See *Crime Committee Hearings* pt. 14, p. 141. In 1950, 167 kilos of heroin "disappeared" from controlled channels in Italy. N.Y. Times, Jan. 9, 1952, p. 11, col. 6. The Bureau of Narcotics considers Italy the major source of the illicit heroin traffic. BUREAU OF NARCOTICS, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1950, p. 7 (1951). However, Turkish illicit factories also play a large part. Their produce is smuggled across the Turkish-Syrian border and shipped to this country from Beirut, Lebanon. *Ibid.*

Conventions of 1925 and 1931 are the mainstays of international control.[59] These conventions provide for national laws to control the manufacture and distribution of narcotics.[60] They also provide standards for the granting of export and import licenses by each nation.[61] Additionally, provision is made

59. The other five conventions are:

(1) The Geneva Agreement on Opium in the Far East (1925), in which eight countries with Asiatic possessions—United Kingdom, India, China, France, Japan, Netherlands, Portugal, and Siam—agreed to establish government monopolies over the wholesale handling and production of opium, to license and control opium retailers, and to prohibit the export of opium to opium-smoking countries. UNITED NATIONS, FIRST OPIUM CONFERENCE AGREEMENT 5-14 (1947).

(2) The Bangkok Agreement on Opium Smoking (1931), in which seven countries with Asiatic possessions—United Kingdom, India, France, Japan, Netherlands, Portugal, and Siam—agreed that the retail sale of opium in Asia was to be by government-owned shops only. The smoking of opium by minors was prohibited. UNITED NATIONS, CONFERENCE ON THE SUPPRESSION OF OPIUM SMOKING 5-15 (1947).

(3) The Convention for the Suppression of Illicit Traffic in Dangerous Drugs (1936), which defined narcotics offenses under the international agreements and provided that narcotics offenders could be extradited. UNITED NATIONS, CONFERENCE FOR THE SUPPRESSION OF THE ILLICIT TRAFFIC IN DANGEROUS DRUGS 5-29 (1947). The criminal provisions of this convention sought to establish a new principle in international law whereby a treaty would define individual offenses directly, instead of through the several governments. However, only 17 countries ratified. The United States abstained. See *Narcotic Drug Control* in INTERNATIONAL CONCILIATION 371-3 (1948).

(4) Protocol of 1946, which brought the existing narcotics conventions under the supervision of the United Nations, and in pursuance of which the U.N. Commission on Narcotic Drugs was established. Previous to this time, the conventions had been supervised by the League of Nations. UNITED NATIONS, PROTOCOL ON NARCOTIC DRUGS (1946).

(5) Protocol of 1948, which brings under the control of the 1931 Geneva Convention any drugs which the World Health Organization finds capable of producing addiction. UNITED NATIONS, PROTOCOL BRINGING UNDER INTERNATIONAL CONTROL DRUGS OUTSIDE THE SCOPE OF THE CONVENTION OF 13 JULY, 1931 (1948).

For a discussion of the international conventions, see generally BAILEY, THE ANTI-DRUG CAMPAIGN (1936); *Narcotic Drug Control* in INTERNATIONAL CONCILIATION 301-73 (1948).

60. The Hague Convention of 1952 binds 67 ratifying countries to use their "best endeavors" to limit the production and distribution of manufactured opium and coca leaf derivatives, and to eradicate opium smoking. 11 LEAGUE OF NATIONS DOC. O.C.I.(I) (1921). The Geneva Convention of 1925 imposes a "legal" obligation on 58 contracting parties to enact laws ensuring the effective control of the production, distribution, and export of opium, cocaine, marihuana, and any other drugs which the World Health Organization finds susceptible to abuse. UNITED NATIONS, SECOND OPIUM CONFERENCE CONVENTION, PROTOCOL, FINAL ACT, AMENDED BY THE PROTOCOL SIGNED AT LAKE SUCCESS, NEW YORK, 11 DECEMBER 1946, Arts. 2, 4, 10, 11 (1947). The Geneva Convention of 1931 provides for similar controls on manufactured narcotics. UNITED NATIONS, CONFERENCE FOR LIMITING THE MANUFACTURE AND REGULATING THE DISTRIBUTION OF NARCOTIC DRUGS, PROTOCOL OF SIGNATURE AND FINAL ACT, AMENDED BY THE PROTOCOL SIGNED AT LAKE SUCCESS, NEW YORK, 11 DECEMBER, 1946, Arts. 6-9 (1947).

61. Pursuant to the Hague Convention of 1912 (binding ratifying powers to use

for each country to submit to an international board an estimate of its needs and supplies.[62] Nations are then forbidden to manufacture more narcotics than needed or to accumulate an unreasonable amount of drugs.[63] And the Central Opium Board may initiate a narcotics embargo against countries not meeting their treaty obligations.[64]

The newest proposal for international control, suggested by the United Nations Commission on Narcotic Drugs, centers about the establishment of an International Opium Monopoly. This Monopoly would be the exclusive agency for the sale and purchase of narcotics. Consumer countries would submit estimates of needs to the Monopoly. On the basis of these estimates, the Monopoly would assign production quotas to the producing countries. A system of international inspection is suggested to police adherence to the quotas.[65] Unlike the existing conventions, the proposed Monopoly would, if effectively implemented, directly control production and distribution of narcotics and do so despite lethargic local enforcement of national narcotics laws. The four largest opium producing countries—Iran, Yugoslavia, India, and Turkey—have accepted the plan "in principle."[66] However, Russian opposition,[67] objections based on the theory that the proposal violates national

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their "best endeavors" to synchronize their opium export controls with the import controls of other countries), the United States passed the Narcotic Drugs Export Act, 38 STAT. 275 (1914), 21 U.S.C. §§ 182-3 (1946). The Act allows narcotic exports only to countries which have ratified the Convention of 1912 and then only if (1) such country maintains, in conformity with that convention, an adequate system of permits and licenses for controlling the imported drugs, (2) the drugs are consigned to an authorized consignee, (3) the Commissioner of Narcotics is satisfied that the drugs are intended for legitimate use, (4) the drugs will not be re-exported, and (5) there is actual demand for them. The maximum penalty for exporting without a license is $5000 and 2 years imprisonment. These export controls, combined with effective internal control of manufacture and distribution, see text at notes 91-6, 122-4 *infra*, have been very successful. According to the Commissioner of Narcotics, "not one grain of narcotics manufactured here finds its way into the international illicit traffic." *Hearings, supra* note 16, at 204. Likewise, the Geneva Convention of 1925, Arts. 12 and 13 provide, among other standards, that no export licenses shall be granted unless the exporter also has an import license from the country of destination.

62. Under the Geneva Convention of 1925, Arts. 21 and 22, estimates are submitted to the Central Opium Board. Under the Geneva Convention of 1931, Arts. 2-4, estimates are submitted to the Supervisory Board.

63. See Geneva Convention of 1931, Arts. 6-9.

64. Geneva Convention of 1925, Art. 24; Geneva Convention of 1931, Art. 14. The Central Opium Board has never used these provisions to initiate a narcotics embargo.

65. See MAYOR'S COMMITTEE, INTERIM REPORT 7-8; MAYOR'S COMMITTEE, REPORT 22; FEDERAL BUREAU OF NARCOTICS, A REVIEW OF INTERNATIONAL AND NATIONAL NARCOTIC CONTROLS 1-2 (1951).

66. See MAYOR'S COMMITTEE, REPORT 22.

67. Of 15 members of the U.N. Commission on Narcotic Drugs, two of them, Russia and Poland, have consistently opposed the creation of the Monopoly. See UNITED NATIONS COMMISSION ON NARCOTIC DRUGS, REPORT OF 6TH SESSION 9, 15 (1951).

sovereignty,[68] and disputes over price [69] and allocation of quotas [70] have thus far precluded international agreement.

Bilateral agreements between the United States and narcotics producing and manufacturing nations also provide a means of constricting the supply of narcotics flowing from foreign nations. The American-Italian agreement on the curtailment of heroin production is illustrative. In 1950, Italian medical firms produced approximately six times the amount of heroin needed to satisfy Italy's medical needs.[71] Since distribution of heroin in Italy was not closely supervised, the Italian heroin surplus supplied most of the illicit narcotics market in the United States.[72] Under the Italian-American agreement, Italy has consented to limit its manufacture of heroin to its own medical needs and to control distribution strictly. For the next few years, until distribution can be effectively controlled, production is to be forbidden completely.[73]

While control at the international level has efficacy on paper, its practical effects have been negligible. International control requires international enforcement. Promise of the latter has yet to appear. Under existing narcotics conventions, the Central Opium Board, theoretically possessed of the power to issue a narcotics embargo, has never exercised that power despite blatant overproduction of narcotics. And implementation of pledges of individual nations to legislate and enforce local narcotics laws controlling production and

68. Objections have been raised especially against on-the-spot U.N. investigation. See N.Y. Times, April 19, 1951, p. 12, col. 6.

69. At the 1951 session of the U.N. Commission on Narcotic Drugs, consuming countries offered $140 a kilogram for crude morphine; producing countries demanded $165. Only $25 for a quantity sufficient for 50,000 injections (or one cent for each 20 injections) separates the countries. See UNITED NATIONS COMMISSION ON NARCOTIC DRUGS, REPORT OF 6TH SESSION 11 (1951); MAYOR'S COMMITTEE, INTERIM REPORT 20; 12 U.N. BULL. 477 (1952).

70. See MAYOR'S COMMITTEE, INTERIM REPORT 8.

71. See note 58 *supra*.

72. *Ibid.* The leniency of Italian courts contributed substantially to Italian failure to control the distribution of medically manufactured heroin. As of 1951, the maximum sentence imposed on narcotics peddlers was two years; the statutory limit was three years. *Crime Committee Hearings* pt. 14, p. 356.

73. In 1950 Mr. Charles Siragusa, an agent of the Bureau of Narcotics, worked out an agreement with Italian authorities whereby heroin production was to be limited to 50 kilos a year and heroin distribution was to be supervised. *Id.* at 355. By 1951 Italy had reduced its annual production from 380 pounds to 60 pounds. However, Italy still possessed a stock of 400 pounds of heroin. Calling attention to the Italian stockpile, Mr. Harry Anslinger, the U.S. Commissioner of Narcotics, proposed that Trygve Lie, U.N. Secretary General, ask the Italian Government to outlaw heroin production for ten years. N.Y. Times, May 2, 1951, p. 17, col. 1. Some months later, Italy halted all heroin production till such time as distribution could be effectively controlled. N.Y. Times, Jan. 9, 1952, p. 11, col. 6.

manufacture has languished in an atmosphere of apathy.[74] While the proposed International Monopoly provides a theoretical means of international enforcement through international inspection, there is no indication that such inspection is possible. Nor is there any indication that many other governments are greatly concerned over the narcotics problem; when the U.N. Commission on Narcotic Drugs requested the views of governments on a new Uniform International Narcotics Convention, the response was startlingly poor.[75]

The lack of common international purpose and interest makes future prospects of international control unlikely. True, bilateral agreements such as the Italian-American agreement provide a limited device for controlling supply. But with one avenue of supply closed, bootleggers may still turn elsewhere, for the lure of profit from the narcotics trade is strong. And since nations producing narcotics derive substantial profits from drugs, their reluctance to enter into such agreements is readily foreseeable.[76] But most important, the communist world has shown no willingness to curb its narcotics production. Either for financial or political reasons, Red China is exporting large amounts of heroin,[77] and opiates from Russia are wending their way

74. In 1950, for example, 333 tons of raw opium "disappeared" from Iran. This is more than 30 times the amount of illicit opium seized by authorities throughout the world in that year. N.Y. Times, Jan. 9, 1952, p. 11, col. 6.

75. Only three governments responded with any alacrity to the suggestion of a Uniform Convention. See MAYOR'S COMMITTEE, INTERIM REPORT 7. The U.N. Economic and Social Council has called for a conference to consider such a convention sometime in 1953, but there is no certainty of agreement. See 12 U.N. BULL. 477-8 (1952).

The proposed Uniform Convention would include the operative provisions of the existing eight agreements, and, at the same time, eliminate obsolete sections. See BUREAU OF NARCOTICS, A REVIEW OF INTERNATIONAL AND NATIONAL NARCOTIC CONTROLS 2-3 (1951); BUREAU OF NARCOTICS, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1950, pp. 1-2 (1951). The need for such a convention is especially acute since many narcotic producing countries have not ratified all of the existing conventions. For list of ratifiers, see *Narcotic Drug Control* in INTERNATIONAL CONCILIATION 371-3 (1948).

76. See note 69 *supra*. Likewise, it seems unlikely that opium producing countries would agree to the far reaching recommendation by the Senate Crime Committee that opium cultivation be abolished and synthetics substituted for opium derivatives. SEN. REP. No. 725, 82d Cong., 1st Sess. 36-7 (1951). Since one factory could produce enough synthetics to satisfy the world's medical needs, this recommendation would, if adopted, greatly ease the problem of narcotics control. See *Narcotic Drug Control* in INTERNATIONAL CONCILIATION 355-6 (1948).

77. Since 1950 there have been indications of increased Chinese and Russian participation in narcotic traffic. The seizure in Japan of Chinese heroin points to a revival of the Manchurian heroin industry formerly run by the Japanese. *Crime Committee Hearings* pt. 14, pp. 429-30. In spite of the fact that China has officially banned opium production, the Bureau of Narcotics reports an offer by the Chinese Communist Government to a British firm in Hong Kong of 500 tons of opium (equal to the world's legitimate requirements for more than one year). BUREAU OF NARCOTICS, A REVIEW OF INTERNATIONAL AND NATIONAL NARCOTIC CONTROLS 6-8 (1951). Reports have also reached the Bureau of a Chinese revival of the Manchurian opium industry and opium dens. *Id.* at 15.

According to data compiled by the Supreme Commander for the Allied Powers in

in illicit channels.[78] Lack of cooperation from non-communist nations might be overcome by United States pressure. But it is dubious that this country would wish to risk international tension over such an issue. And in any event, there is no means of forcing agreement from the communist orbit. Thus the major burden of solving the narcotics problem rests, in the foreseeable future, with the pattern of federal and state control in the United States.

The Pattern of Domestic Control

The purpose of domestic control of narcotics supply is twofold: (1) to prevent diversion of narcotics from channels established for the importation and circulation of medically needed narcotics; and (2) to prevent illicit importation and circulation of narcotics which never went through established channels. Enforcement of federal laws is entrusted to the Secretary of the Treasury, acting through his deputy, the Commissioner of Narcotics.[79] The Commissioner heads a special squad of narcotics enforcement officers. State laws are ordinarily enforced as part of the general police duties rather than by a specific central narcotics agency.

Federal controls over the supply of narcotics stem primarily from the Harrison Act,[80] Narcotics Importation Act,[81] and Marihuana Tax Act.[82] Under the Narcotics Importation Act, entry of all opiates and coca leaf drugs is prohibited except for such quantities of raw opium and coca leaves as the Secretary of the Treasury may deem necessary to satisfy the nation's medical and scientific needs.[83] The Harrison Act—a regulatory statute in

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Japan, Communist China is using the profits from a vast illicit traffic in narcotics to help finance her part in the Korean war. Three hundred seventy-seven Chinese communists and 269 North Koreans have been arrested for smuggling heroin from Red China into Japan. New Haven Evening Register, Feb. 28, 1953, p. 5, col. 1.

78. The British Government alleged before the U.N. Commission on Narcotic Drugs that narcotics were diverted from Russian army stock into illicit traffic in the British Zone of Germany. See MAYOR'S COMMITTEE, INTERIM REPORT 29.

79. 46 STAT. 586 (1930), 5 U.S.C. § 282(b) (1946). Prior to 1930, control over the import and export of narcotics was entrusted to a Federal Narcotics Control Board, composed of the Secretaries of State, Treasury, and Commerce. 35 STAT. 614 (1909); 38 STAT. 275-7 (1914).

80. INT. REV. CODE §§ 2550-65, 3220-8.

81. 35 STAT. 614 (1909), as amended, 21 U.S.C. § 173 (1946).

82. INT. REV. CODE §§ 2590-2604, 3230-9.

83. The importation of raw opium for heroin production is expressly forbidden. 35 STAT. 614 (1909), as amended, 21 U.S.C. § 173 (1946). The Surgeon General of the U.S. P.H.S. is directed by statute to investigate the "use and abuse" of narcotics and to submit yearly estimates of the country's legitimate medical needs to the Secretary of the Treasury. The Secretary may, but is not obligated to, use these estimates in setting import quotas. 58 STAT. 692 (1944), 42 U.S.C. § 242 (1946).

Since raw opium and coca leaves are not produced in the United States, the Importation Act, in effect, gives the Commissioner of Narcotics absolute power over the distribution and consumption of these drugs. See BUREAU OF NARCOTICS, TRAFFIC IN OPIUM AND OTHER DANGEROUS DRUGS FOR THE YEAR ENDED DECEMBER 31, 1950, pp. 31-2 (1951).

the guise of a tax measure—requires importers and manufacturers to purchase and affix tax stamps to all opiate and cocaine packages.[84] In addition, importers, manufacturers, wholesalers, retailers, and doctors must register and pay a graduated tax for utilization of narcotics.[85] Transfer of narcotics can only be by registered persons and through the use of a special order form, which the transferee must obtain from a director of internal revenue.[86] A transferee may use such a form only in the conduct of a "lawful business" or in the "legitimate practice of his profession."[87] There are no special limitations on the importation of marihuana, but the Marihuana Tax Act, like the Harrison Act, requires stamp taxes, registration, and order forms,[88] and further provides for the licensing of marihuana millers[89] and for the payment of special transfer taxes.[90]

Government regulation attempts to channel legitimate narcotic imports solely for medical and scientific needs. Since raw opium and coca leaves are legitimately imported only pursuant to Government order, their supply is theoretically restricted to these needs. Then, after legal importation, the Commissioner of Narcotics assigns the raw product to manufacturers for

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The Opium Poppy Control Act, 56 STAT. 1045 (1942), 21 U.S.C. § 188 (1946) prohibits the cultivation of opium without a license from the Secretary of the Treasury. Mr. H. J. Anslinger, the Commissioner of Narcotics, states that no licenses have been granted under this Act, nor is it likely that any will be granted. Anslinger, *The Federal Narcotic Laws*, 6 FOOD DRUG COSMETIC L.J. 743, 746 (1951).

84. INT. REV. CODE §§ 2550, 2552. Regulated drugs under the Importation and Harrison Acts include, in addition to opium and coca leaves, the synthetic, isonipecaine (demerol), and any other drugs found by the Secretary of the Treasury to have an addiction-forming quality similar to morphine or cocaine. 58 STAT. 721 (1944), as amended, 21 U.S.C. § 171 (1946); INT. REV. CODE § 3228. Acting under this statutory authorization, the Secretary of the Treasury has extended the Acts' coverage to include the following synthetics: amidone, isoamidone, keto-bemidone, bemidone, NU-1196, NU-1779, NIH-2933, NIH-2953, CB-11, NU-2206. See 26 U.S.C.A. § 3228(f) (Supp. 1952). However, since synthetics are produced in the United States, the Commissioner's control over their production is not as ironclad as over opium and coca leaf derivatives. So far, however, domestic producers of synthetics have voluntarily abided by the Commissioner's rulings. See *Hearings, supra* note 16, at 204, 206.

85. Once registered, importers and manufacturers are taxed $24 per annum; wholesalers $12; retailers $3; physicians, dentists, veterinarians, and persons engaged in scientific research $1. INT. REV. CODE §§ 3220, 3221. Registered persons are required to keep such records and make such reports as the Secretary of the Treasury shall require. *Id.* § 2555.

86. *Id.* § 2554(a). Excepted from the order form requirement are transfers to government officials (*id.* § 2554(c)(4)), transfers in the Virgin Islands (*id.* § 2554(b)), and retail sales to bona fide medical patients (*id.* § 2554(c)(1),(2)). For discussion of the last exception, see note 94 *infra*.

87. *Id.* § 2554(g). See note 94 *infra*.

88. *Id.* §§ 2590, 2592 provide for stamp taxes; §§ 3230, 3231(a) provide for registration; § 2591 provides for order forms.

89. *Id.* § 3231(b).

90. Registered transferees pay $1 an ounce. *Id.* § 2590(a)(1). Unregistered transferees are assessed a prohibitive $100 an ounce. *Id.* § 2590(a)(2).

production.[91] From the time of entry until ultimate dispensation, records of the legitimate drug traffic are complete because of the requirement that only registered persons may transfer, and transfer may occur only by use of special order forms. Thus detection of diversion from legitimate channels becomes relatively easy. At the same time adherence to legitimate transfer is coerced since a failure to comply with any of the provisions of the acts, such as dealings in packages which do not have tax stamps affixed, non-payment of taxes, or transferring without order forms, constitutes a criminal offense.[92] At only one point, the ultimate sale to consumer, do transfer and tax provisions fail to guard against diversion. Here, however, doctors and pharmacists must be registered;[93] and at the threat of penal sanction the former may only dispense narcotics in the "course of professional practice"[94] and the latter only "in good faith" and upon prescription.[95] Control over retail outlets is strengthened by court decisions holding wholesalers and pharmacists liable to prosecution if they have reason to know that a doctor or retailer they are supplying is prescribing or selling illegally.[96]

91. In practice, the Commissioner assigns legally imported narcotics to three factories for medicinal production. *Hearings, supra* note 16, at 204.

92. INT. REV. CODE §§ 2557, 2596.

93. *Id.* §§ 3220, 3221, 3230, 3231(a).

94. *Id.* §§ 2554(c)(1), 2591(b)(1). The Commissioner interprets "course of professional practice" to exclude both the ambulatory treatment of addicts and the relief of addicts' discomfort. TREASURY DEPARTMENT, BUREAU OF NARCOTICS, PAMPHLET N, No. 56, pp. 1-6 (rev. ed. 1935). Aside from cases of incurable illness and severe pain the Commissioner finds the use of narcotics justified in only two contingencies: (1) if an addict is so old and feeble that a withdrawal might cause death; and (2) if a single dose is necessary to enable an addict to reach a hospital in comfort. *Id.* at 5-6.

Federal decisions have not consistently followed the Commissioner's interpretation of "course of professional practice." Courts have held that a doctor may "in good faith" administer a few doses of narcotics to relieve an addict's suffering. For example, in Linder v. United States, 268 U.S. 5 (1925), a physician who dispensed small doses of morphine for relief of conditions incident to addiction was held to have committed no crime. *Accord:* Weaver v. United States, 111 F.2d 603 (8th Cir. 1940); Strader v. United States, 72 F.2d 589 (10th Cir. 1934). But a doctor may not prescribe narcotics for habitual use. Webb v. United States, 249 U.S. 96 (1919) (physician may not issue morphine to an addict for the purpose of keeping him comfortable by maintaining his customary dosage). See also Grigg v. Bolton, 53 F.2d 158 (9th Cir. 1931), *cert. denied*, 285 U.S. 538 (1932); Manning v. United States, 287 Fed. 800 (8th Cir. 1923). However, courts have drawn no clearly defined line between legal and illegal dispensing. In arriving at a decision, a court may consider: (1) the quantity and frequency of administration—United States v. Brandenburg, 155 F.2d 110 (3rd Cir. 1946); Hobart v. United States, 299 Fed. 784 (6th Cir. 1924); (2) whether the price charged was in excess of usual medical fees—Hawkins v. United States, 90 F.2d 551 (5th Cir. 1937); and (3) whether the recipient was a regular patient or merely an addict in search of a peddler—Barbot v. United States, 273 Fed. 919 (4th Cir. 1921).

95. INT. REV. CODE §§ 2554(c)(2), 2591(b)(2).

96. For liability of wholesalers, see, *e.g.*, Direct Sales Co. v. United States, 319 U.S. 703 (1943). For liability of pharmacists, see, *e.g.*, Friedman v. United States, 260 Fed. 388 (6th Cir.), *cert. denied*, 250 U.S. 671 (1919).

The three major narcotics acts also attempt to cope with illicit traffic stemming from the supply of narcotics smuggled into or illicitly grown within the country. The Narcotics Importation Act not only provides direct prohibitions against smuggling, but also makes it illegal to "receive or conceal" narcotics with knowledge of their illegal importation.[97] The statute states that possession of narcotics is sufficient to convict unless the defendant explains his possession to the satisfaction of the jury.[98] Courts hold that, under the statute, possession gives rise to a twofold presumption: that the narcotics were illegally imported and that the defendant had knowledge of their illegal importation. Since a defendant can rarely show that the narcotics were legally produced in the United States—and since handling of illegal domestic narcotics is a crime under other statutes—possession alone will ordinarily result in conviction, unless the defendant can show that he obtained the narcotics through a legitimate prescription.[99] And in the case of heroin, which has not been produced legally in the United States for thirty years, it would seem that the presumptions attaching to possession are irrebuttable.[100] Similarly, the Harrison Act makes it unlawful to "purchase" narcotics except in or from an originally stamped package; and possession of an unstamped package is presumptive of guilt.[101] The Marihuana Act, which makes it unlawful to acquire marihuana without paying a special transfer tax, makes proof of possession and the absence of an order form presumptive of guilt.[102] Thus, the criminal sanctions against handlers of the drugs actually apply to every stage of the illicit traffic from inception to ultimate consumption.

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97. 35 STAT. 614 (1909), as amended, 21 U.S.C. § 174 (1946).

98. *Ibid.*

99. For example, in Copperthwaite v. United States, 37 F.2d 846 (6th Cir. 1930), the court approved and applied the presumption that an unstamped package was illegally imported and that the recipient would know of such unlawful importation. See also Stopelli v. United States, 183 F.2d 391 (9th Cir. 1950); Pitta v. United States, 164 F.2d 601 (9th Cir. 1947); United States v. Feinberg, 123 F.2d 425 (7th Cir. 1941); United States v. Moe Liss, 105 F.2d 144 (2d Cir. 1939).

100. See *Hearings, supra* note 16, at 64.

101. INT. REV. CODE § 2553(a). The Seventh and Eighth Circuits tried to wipe out the force of this presumption by holding that it did not extend to venue and that the Government must establish the place of purchase. Donaldson v. United States, 23 F.2d 178 (8th Cir. 1927); DeMoss v. United States, 14 F.2d 1021 (7th Cir. 1926); Brightman v. United States, 7 F.2d 532 (8th Cir. 1925). The Supreme Court, however, in Casey v. United States, 276 U.S. 413, 416 (1928) held that the Government could establish the place of purchase by inference.

102. INT. REV. CODE § 2593(a). Another possible, although restricted, basis for the prosecution of peddlers lies in *id.* §§ 2567-70, which impose a special $300 per pound tax on smoking opium manufactured in the United States and provide for a minimum penalty of 5 years or $10,000 fine for failure to pay. See Charley Toy v. United States, 266 Fed. 326 (2d Cir.), *cert. denied*, 254 U.S. 639 (1920). This is of minor importance since the importation of opium for purposes of preparing it for smoking is, in any case, punishable under the Importation Act.

The penalties for engaging in illicit traffic in narcotics are severe. The recently passed Boggs Act [103] establishes penalties of two to five years for a first offense, five to ten years for a second offense, and ten to twenty years for a third offense, under the Importation, Harrison and Marihuana Tax Acts. At the same time, a party engaging in illicit traffic may easily be violating several provisions at once. Thus sentences can be compounded, since each violation may provide a separate and additional count in an indictment.[104] However, while penalties are theoretically severe, courts have evidenced reluctance to use the full breadth of sanction in sentencing offenders. In order to fortify imposition of penalties against a possible judicial leniency, the Boggs Act also provides that courts may neither grant probation nor suspend sentences for second and subsequent narcotics offenders.[105] Even under the Boggs provisions, however, there is still room for light sentences.

Subsidiary statutes provide additional weapons for the fight against illicit narcotics traffic. A seizure statute provides for the forfeiture of all vehicles—other than common carriers—used to transport or conceal contraband narcotics.[106] And the courts have decided that innocence of the vehicle's owner will not serve as a defense unless the vehicle was stolen.[107] A further statute holds masters of vessels financially liable for the value of any narcotics not listed on their manifests.[108] Liability attaches even when the master is unaware of narcotics smuggled in by crew members or passengers.[109] Finally, an informer's statute authorizes the Commissioner of Narcotics to pay such sums as he deems appropriate for information which results in a seizure of contraband narcotics.[110] The former two statutes of course function to penalize, through property loss, parties who may contribute to the illicit traffic. But primarily, all three statutes are aimed at inducing the vigilance of private parties either to prevent illicit traffic or to reveal its existence to enforcement officers.

Paralleling federal control, states have also regulated illicit traffic in narcotics. Forty-four states have adopted the Uniform Narcotic Drug Act or its equiva-

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103. 65 STAT. 767 (1951), 21 U.S.C. § 174 (Supp. 1952); INT. REV. CODE § 2551(b).

104. See, *e.g.*, Charley Toy v. United States, 266 Fed. 326 (2d Cir.), *cert. denied*, 254 U.S. 639 (1920).

105. 65 STAT. 767 (1951), 21 U.S.C. § 174 (Supp. 1952); INT. REV. CODE § 2551(b). See note 131 *infra*.

106. 53 STAT. 1291 (1939), as amended, 49 U.S.C. §§ 781, 782 (1946).

107. See United States v. One Oldsmobile Sedan, 75 F. Supp. 83 (E.D. La. 1948) (innocence of owner no defense where he consented to use of car); United States v. Andrade, 181 F.2d 42 (9th Cir. 1950) (illegality of possession must be established by car's owner).

108. If the narcotic is smoking opium, the master is liable to a penalty of $25 an ounce; in the case of any other narcotics, he is liable to a penalty equal to the value of the drugs. Such penalty constitutes a lien upon the vessel which may be enforced by libel in rem proceedings. 38 STAT. 277 (1914), 21 U.S.C. § 184 (1946).

109. See The Ivor Heath, 275 Fed. 67 (E.D. Va. 1921).

110. 46 STAT. 850 (1930), 21 U.S.C. § 199 (1946).

lent.[111] The Act requires the licensing of narcotics manufacturers, growers, and wholesalers.[112] Like the federal statutes, it provides for order forms and restricts dispensing by doctors and pharmacists.[113] The states which have not adopted the Act—Kansas, Massachusetts, New Hampshire, and Washington —nevertheless forbid transfer of narcotics except for legitimate medical purposes.[114] And in every state unauthorized possession is sufficient for conviction.[115] Penalties under state law may vary greatly, the maximum penalties running from 1 to 15 years.[116] Currently, many states indicate that they may follow the Federal Government by legislating "little Boggs Acts" to lengthen penalties and prohibit probation and suspended sentences for repeating offenders.[117]

Though state sanctions and penalties are generally no different from federal ones, they nevertheless substantially increase enforcement potential.[118] Theoretically, federal officials concentrate on interstate traffickers and state officials on intrastate peddling.[119] But in reality, state and federal officials work together. Their cooperation is significant in three respects. State and local police provide added manpower to root out illicit traffic. The existence of state narcotics laws also permits enforcement officials to hand over peddlers for prosecution in the forum where penalties are more severe.[120] Finally,

111. SEN. REP. No. 725, 82d Cong., 1st Sess. 25-6 (1951).

112. UNIFORM NARCOTIC DRUG ACT § 3 (1932).

113. *Id.* §§ 5-7.

114. KAN. STAT. ANN. c. 65, §§ 615-18 (1950); MASS. LAWS ANN. c. 94 §§ 197-217 (1947); N.H. REV. LAWS c. 256, §§ 49-55 (1942); WASH. REV. STAT. ANN. c. 7, §§ 2509-14 (Remington, 1932).

115. UNIFORM NARCOTIC DRUG ACT § 2 (1932). States which have not adopted the Act also punish unauthorized possession. KAN. STAT. ANN. c. 65, § 615 (1950); MASS. LAWS ANN. c. 94, § 211 (1947); N.H. REV. LAWS c. 256, § 50 (1942); WASH. REV. STAT. ANN. c. 7, §§ 2509-13 (Remington, 1932).

116. See, *e.g.*, N.H. REV. LAWS c. 256, § 55 (1942) (maximum penalty one year); N.Y. PEN. LAW § 1751 (maximum penalty 15 years).

117. Mr. H. J. Anslinger, the Commissioner of Narcotics, reports that the Bureau is urging all states to adopt provisions comparable to the Boggs penalties. As of 1951, West Virginia, Tennessee, Maryland, New Jersey, Oklahoma, and the Territory of Alaska had done so. Anslinger, *The Federal Narcotic Laws*, 6 FOOD DRUG COSMETIC L.J. 743, 748 (1951). See also GOLDSTEIN, REPORT 77-85; N.Y. Times, April 26, 1951, p. 42, col. 8.

Some states are especially attempting to discourage sales to minors by punishing such sales with special severity. Thus a recent Illinois law provides for a sentence of two years to life for sales to minors, as opposed to one to five years for sales to adults on a first offense. 38 ILL. ANN. STAT. § 192.23 (Smith-Hurd, Supp. 1952). Likewise, N.Y. PEN. LAW § 1751 sets a penalty of 5 to 15 years for sales to minors as opposed to 2 to 15 years for sales to adults.

118. UNIFORM NARCOTIC DRUG ACT § 21 (1932) prevents duplication of penalties by forbidding state prosecution for a narcotics violation for which an acquittal or conviction has been obtained in a federal court.

119. See STATEMENT COMM'R OF NARCOTICS, UNIFORM NARCOTIC DRUG ACT 4 (1932).

120. Mr. G. W. Cunningham, Deputy Commissioner of Narcotics, has testified that the Bureau prosecutes most of its New York City cases in the state courts where

enforcement by state officials can overcome difficulties in federal enforcement engendered by the Fourth Amendment's search and seizure provisions. Speaking practically, states are not subject to the Fourth Amendment's strictures.[121] Thus state officials may obtain evidence through what might be, under federal law, an unreasonable search or seizure and turn such evidence over for federal prosecution—provided the state officials did not act in accordance with a federally conceived plan.[122]

Federal and state narcotics laws have established practically diversion-proof channels for the distribution of *legally* imported narcotics. Due to the completeness and efficacy of control over narcotics from the time of their legal importation until they reach medical retail outlets, there is—according to the Commissioner—no diversion until retail outlets are reached.[123] And diversion from medical retail outlets is rare. While courts have construed the "good faith" and "course of professional practice" requirements on dispensation slightly more broadly than the Commissioner might allow, most doctors apparently remain within the very narrow confines of the Commissioner's own limits on retail dispensation.[124] Thus the supply of narcotics which feeds the illicit narcotics market stems not from legitimate importations, but rather from those narcotics smuggled into the country.

In sharp contrast to control over legal imports, federal and state narcotics laws have failed to block illicit traffic in smuggled or illegally grown narcotics. Of course, the illegal importer and grower of the drugs does not register his wares. Thus there is no means other than police action for tracing the illicit traffic from its inception to ultimate dispensation. Since narcotics are small in bulk and easily concealable, discovery by police action is extremely

sentences are severer and trials take place more promptly. *Hearings, supra* note 16, at 68. When Bureau agents, together with New York police, trapped "Waxey" Gordon, a leader in the narcotic traffic, he was turned over to New York officials for prosecution as a fourth offender with a life sentence awaiting him upon conviction. SEN. REP. No. 725, 82d Cong., 1st Sess. 32-3 (1951).

121. Wolf v. Colorado, 338 U.S. 25 (1949).

122. Thus in Symons v. United States, 178 F.2d 615 (9th Cir. 1949), the court held that there was no unconstitutional search and seizure where state officers broke a window, seized narcotics, and delivered them to federal agents for prosecution. However, in United States v. Falloco, 277 Fed. 75 (W.D. Mo. 1922), the court excluded evidence obtained by state officers where it was shown that they had acted under the supervision of federal officials. For Bureau of Narcotics' use of state prosecution to avoid search and seizure difficulties, see MAYOR'S COMMITTEE, REPORT 25.

123. *Hearings, supra* note 16, at 204.

124. See note 94 *supra* for the differing interpretations of the courts, on one hand, and the Commissioner, on the other. But for a view of what seems to be the general pattern of doctor activities see TERRY & PELLENS, THE OPIUM PROBLEM 771 (1928). Both Mr. H. J. Anslinger, Commissioner of Narcotics, and Mr. G. W. Cunningham, Deputy Commissioner of Narcotics, have testified that diversions by doctors and pharmacists are rare. *Hearings, supra* note 16, at 63, 204.

difficult. This fact, coupled with practical and legal limitations on enforcement, hamstrings control of illicit traffic. Because of the difficulty of detection of the traffic, arrests of peddlers ordinarily depend on carefully arranged sales to undercover agents. They, therefore, consume much time and manpower.[125] The United States Narcotics Bureau's 1951 staff of 188 was hardly adequate for this task.[126] While the recent publicity given to the illicit traffic has resulted in increases in both federal and state enforcement squads, it is too early to predict whether these increases are sufficient.[127] Even with increased narcotics squads, however, enforcement faces serious obstacles in the form of the legal doctrines of "entrapment" and search and seizure. The difficulties of discovery resulting from the concurrence of the easy concealability of narcotics packages with the Fourth Amendment's strictures on search and seizure [128] are partially overcome by the ability of state officers to operate outside of the Fourth Amendment.[129] But since federal enforcement is by far the most active weapon against illicit traffic, limitations on investigations, confiscation, and arrest still remain. At the same time, unless officials have "reasonable grounds" for suspicion of an individual when they attempt to induce sales to undercover agents, the peddler may escape conviction on a plea of entrapment.[130]

125. For examples of the painstaking undercover work required to gain the confidence of large peddlers and to arrange narcotic sales, see *Crime Committee Hearings* pt. 14, pp. 404-17.

126. *Id.* at 419, 425, 430-1. The Bureau lacks funds as well as men. When federal agents required $5000 to make an undercover purchase from two major peddlers, the money was obtainable only from the New York County Attorney. Hence, the peddlers were prosecuted in the state courts. *Id.* at 419. In 1950 the Bureau had virtually the same appropriation that was made available to it at its inception, in spite of the fact that the application of the federal narcotics laws yielded a net profit of over $228,000 in that year. MAYOR'S COMMITTEE, REPORT 25-6.

127. In 1951 the Commissioner of Narcotics considered California, Florida, and Pennsylvania as the only states where the local narcotic enforcement agencies were "adequate." N.Y. Times, July 2, 1951, p. 10, col. 6. The New York City narcotic squad numbered only 18 in 1950. MAYOR'S COMMITTEE, INTERIM REPORT 11. Buffalo (the only other city in New York state with a narcotic force) had only two men on its squad. GOLDSTEIN, REPORT 87. The Bureau of Narcotics was increased to 232 agents by the end of 1951. Its New York staff had grown from 40 to 65. MAYOR'S COMMITTEE, INTERIM REPORT 9. New York City's narcotic squad has expanded from 18 members in 1950 to 100 in 1952. MAYOR'S COMMITTEE, INTERIM REPORT 11. There have also been large increases in the narcotic squads of Chicago (*Crime Committee Hearings* pt. 14, p. 284) and Buffalo (GOLDSTEIN, REPORT 87).

128. See, *e.g.*, Johnson v. United States, 333 U.S. 10 (1948) (narcotics agents had no right to search hotel room from which the odor of burning opium was emanating, nor to arrest the sole occupant of the room without a warrant). See also Worthington v. United States, 166 F.2d 557 (6th Cir. 1948) (anonymous phone call and other hearsay evidence was not sufficient to establish the necessary probable cause for arrest and search of premises without a warrant).

129. See text at notes 121-2 *supra*.

130. In Morei v. United States, 127 F.2d 827 (6th Cir. 1942), the defense of entrap-

Federal and state penal sanctions have been singularly ineffective in counteracting illicit traffic. Even where enforcement results in confiscation of narcotics, arrest, and the imposition of heavy penalties under the Boggs Act,[131] there is little indication that this alone can halt illicit traffic. It is not the leaders of the illicit traffic, but rather their agents, the peddlers, who most frequently handle the actual drugs.[132] Thus, even when penal sanctions operate, they reach largely peddlers. Assuming that these peddlers subsequently refrain from engaging in illicit traffic as a result of the penalties—a tenuous assumption—illicit traffic still remains unchecked. Because of the high price of narcotics and the complete dependence of addicts on an available supply, the addicts themselves in order to support their habits provide a constant reservoir of potential peddlers.[133] And in spite of an informer statute,[134] addicts have refrained from testifying against their source of supply.[135] At the same time, enforcing penal laws against the peddler produces the curious paradox of inducing higher prices for the drugs. This, in turn, provides greater impetus for an addict to become a peddler or to engage in other types of criminal activity in order to meet the prices. It is thus necessary to attack not only the source of supply, but also the source of demand.

CONTROLLING THE DEMAND

The Senate Crime Committee and other investigatory bodies have recommended, on the one hand, that the addict be treated not as a criminal, but as a patient.[136] On the other hand, they have sponsored penal measures, like

ment succeeded where a Government informer induced a sale by defendant who had a good reputation and apparently no previous dealings in contraband narcotics. See Cermak v. United States, 4 F.2d 99 (6th Cir. 1925); Butts v. United States, 273 Fed. 35 (8th Cir. 1921). But if defendant has illegal possession of narcotics or criminal intent to sell before Government agents urge a sale, the defense of entrapment will fail. See, *e.g.*, Louie Hung v. United States, 111 F.2d 325 (9th Cir. 1940); Swallum v. United States, 39 F.2d 390 (8th Cir. 1930); Fiunkin v. United States, 265 Fed. 1 (9th Cir. 1920).

131. Prior to the passage of the Boggs Act, the Bureau of Narcotics attacked the leniency of narcotics sentences—which averaged 16 months—as a major source of the narcotics problem. *Crime Committee Hearings* pt. 14, p. 430. See also *Hearings, supra* note 16, at 51.

132. See SEN. REP. No. 725, 82d Cong., 1st Sess. 33 (1951). According to the Senate Crime Committee, the "big shot" never enters the picture, except perhaps to be seen talking to his assistants. He makes no deliveries and accepts no money direct from a purchaser. *Id.* at 31.

133. See investigations by the Chief Probation Officer of the Magistrates' Courts in New York City showing many cases where an addict, in order to get his own supply free, would make arrangements to get five or six other users, reported in GOLDSTEIN, REPORT 47-8.

134. See note 110 *supra.*

135. The unwillingness of addicts to disclose the identity of peddlers apparently stems both from a fear of losing their source of supply and a fear of underworld retaliation. See GOLDSTEIN, REPORT 59; SEN. REP. No. 725, 82d Cong., 1st Sess. 29 (1951).

136. SEN. REP. No. 725, 82d Cong., 1st Sess. 29 (1951).

the Boggs Act,[137] which increase prison terms for addicts. The same ambivalent approach is illustrated by the New York Attorney General's Report which lauds the passage of a New York law lowering the minimum amount of narcotics necessary for possession to constitute a felony,[138] and, at the same time, maintains that addicts should be non-criminally confined and treated.[139] In theory, increased penalties and treatment of the addict need not conflict: if addicts were placed in compulsory non-criminal confinement for treatment, increased penalties would operate only against peddlers. Or in the alternative, if *all* addicts, once convicted, were hospitalized rather than incarcerated, the approaches might be more consistent. But in practice this is not the case, and consequently the attack on demand for narcotics generally consists of treating some addicts and imprisoning many others.

Treating the Addict

The cure of the addict demands his separation from the drug and steps to rehabilitate him so he may assume a normal constructive social role. The first step in treatment is "withdrawal"—separation of the addict and the drug. With cocaine and marihuana addicts this entails no discomfort. With opiate addicts the administration of decreasing doses over a two-week period and the use of methadone minimize discomfort.[140] Clearly, during this period, hospitalization is necessary, for ambulatory treatment would provide no control over the addict and the temptation to resort to narcotics would be ever present.[141] But it is not sufficient that the patient be separated from the drug. Hospitalization, to have any effect on the underlying psychiatric causes of addiction, must continue long enough for the patient to receive rest, vocational rehabilitation, and, above all, psychiatric help.[142] Even after a patient is released, it is agreed that effective treatment and the prevention of a relapse entail a lengthy psychiatric follow-up program to help the addict adjust to his family, his community, and his job.[143] However, even under conditions creating what is currently considered "good"

137. SEN. REP. No. 725, 82d Cong., 1st Sess. 29 (1951).

138. GOLDSTEIN, REPORT 80. N.Y. PEN. LAW § 1751, as amended by N.Y. Laws 1951, c. 529, makes possession of one quarter ounce of narcotics a felony, whereas previously possession of two ounces was only presumptive evidence of intent to sell. The N.Y. Attorney General endorsed this change, even though one quarter ounce is admittedly not an unusual amount for addicts to keep for their personal use. See GOLDSTEIN, REPORT 79.

139. *Id.* at 92-4.

140. See *Crime Committee Hearings* pt. 14, p. 149; *Hearings, supra* note 16, at 159-61.

141. See Reichard, *Narcotic Drug Addiction*, 4 DISEASES OF THE NERV. SYS. 275, 279 (1943); *Hearings, supra* note 16, at 161.

142. GOLDSTEIN, REPORT 93; Reichard, *Narcotic Drug Addiction*, 4 DISEASES OF THE NERV. SYS. 275, 280-1 (1943); *Hearings, supra* note 16, at 161-2.

143. See SEN. REP. No. 725, 82d Cong., 1st Sess. 34 (1951); GOLDSTEIN, REPORT 93-4; MAYOR'S COMMITTEE, REPORT 48-9. A follow-up program is especially necessary in

treatment, there is no assured cure; relapses into the habit may occur and no one can tell just how high the rate of relapse may be.[144]

The federal narcotics hospitals at Lexington, Kentucky, and Fort Worth, Texas, provide treatment for convicts, probationers, and voluntary patients.[145] Addicts convicted not only of crimes related to narcotics traffic but also of any other crimes against the United States are sent to the hospitals unless the Attorney General finds that the "nature of [their] crime" or their "apparent incorrigibility" renders such a course inadvisable.[146] However, no provision is made for the admission of state convicts. Once admitted, the federal convicts may not be released through commutation of sentence or parole until the Surgeon General deems their treatment completed.[147] Federal courts may also require treatment at the hospitals as a condition of granting probation.[148] In addition, Lexington and Fort Worth admit voluntary patients at little or no cost.[149] Indeed, over 50 percent of the patients are voluntary.[150]

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view of the prejudices released addicts have to face. Dr. J. D. Reichard, physician at the Lexington Hospital, writes that post-hospitalization placement of the addict is difficult because people regard the released addict as "incurable, unreliable, and prone . . . to crimes of violence or of perversion." When the hospital is unable to place an addict in a friendly environment, he may have no alternative but to rejoin his former addict associates. Reichard, *Narcotic Drug Addiction*, 4 DISEASES OF THE NERV. SYS. 275, 281 (1943).

144. Whether all addicts can be cured through proper treatment is impossible to determine until optimum treatment facilities have existed a sufficient length of time to permit of evaluation. Under present treatment facilities, Dr. K. W. Chapman, Assistant Chief, Division of Hospitals, U.S.P.H.S., testified that 15% is "a pretty good figure" for the percentage of final cures achieved. GOLDSTEIN, REPORT 94. Dr. Vogel, however, believes there is no such thing as an incurable addict. *Crime Committee Hearings* pt. 14, p. 288. The New York Attorney General is of the opinion that certain users are "hopelessly addicted." GOLDSTEIN, REPORT 90. Teen-agers, who are often not yet completely habituated and who are not suffering from severe maladjustments, probably have the best chance of complete cure. See *Id.* at 90-2. See also note 21 *supra*.

145. Public Health Service hospitals for addicts were authorized by 45 STAT. 1085 (1929), as amended, 42 U.S.C. § 257 (1946). The Lexington Hospital was opened in 1935 and the Fort Worth Hospital in 1938. *Crime Committee Hearings* pt. 14, p. 238. Addicts admitted for treatment are those "who habitually use" opium, coca leaves, marihuana, peyote, or their derivatives "so as to endanger the public morals, health, safety, or welfare, or who . . . have lost the power of self-control with reference to [their] addiction." 58 STAT. 683 (1944), 42 U.S.C. § 201 (1946).

146. 58 STAT. 699 (1944), 42 U.S.C. § 259(a) (1946). The initial recommendation for the hospitalization is ordinarily made by the trial judge. The Attorney General's office accepts the recommendation in cases where the convict's criminality is believed secondary to his addiction. See *Crime Committee Hearings* pt. 14, p. 135.

147. 58 STAT. 699 (1944), 42 U.S.C. § 259(b) (1946).

148. 58 STAT. 700 (1944), 42 U.S.C. § 259(e) (1946).

149. 58 STAT. 701 (1944), 42 U.S.C. § 260 (1946). Ninety-five percent of the voluntary patients are unable to pay and are treated free. The other 5% are charged $5 a day. *Crime Committee Hearings* pt. 14, p. 248. Congress has provided that voluntary admittance be kept confidential and not used in court proceedings. 58 STAT. 701 (1944), 42 U.S.C. § 260 (1946).

150. *Crime Committee Hearings* pt. 14, p. 135. While at any one time 50% of the hospital inmates are convicts or probationers, volunteers constitute about 80% of the

The voluntary patients may, by virtue of court decision, leave the hospitals at any time.[151] At present, the hospitals' approximately 2,000 beds are sufficient to accommodate all first-time male applicants. Others must ordinarily wait for admittance.[152]

At the federal hospitals, treatment for both prisoners and voluntary patients is designed to last at least four months. The treatment consists of withdrawal, recreational and vocational rehabilitation, and psychiatric care.[153] Recently, the Public Health Service revealed its plans to establish follow-up centers throughout the country and thus assist former patients in adjusting to their environments.[154] The first of such centers will be in New York and Chicago.[155] Additionally, for the first time, some attempt is being made to segregate youthful addicts undergoing treatment.[156] This step is directed at combating a spread of addiction and criminal indoctrination previously made

admissions. This discrepancy is due to the fact that many voluntary patients stay only a short while. *Id.* at 242. See VOGEL, TREATMENT OF THE NARCOTIC ADDICT BY THE U.S. PUBLIC HEALTH SERVICE 6 (1948).

151. Ex Parte Lloyd, 13 F. Supp. 1005 (E.D. Ky. 1936) (to enforce agreements signed by voluntary patients to remain at hospital violates Fifth and Thirteenth Amendments). See MAYOR'S COMMITTEE, REPORT 28-9; VOGEL, TREATMENT OF THE NARCOTIC ADDICT BY THE U.S. PUBLIC HEALTH SERVICE 6 (1948). Voluntary patients are likely to leave at two periods in their treatment: (1) during withdrawal; (2) after two or three months, when they have successfully completed withdrawal, gained weight, energy, and an optimistic outlook. *Ibid.* To prevent voluntary patients from leaving, Lexington authorities have devised the so-called "blue grass" procedure. Under this procedure, voluntary patients who leave against advice will not be readmitted unless they go to a Kentucky court and plead guilty under a state anti-addiction law. The Kentucky courts sentence such addicts to twelve months in the workhouse, but then probate the sentence conditional on the addicts staying at Lexington Hospital as long as the authorities deem necessary. *Crime Committee Hearings* pt. 14, p. 243. The drawback is that the addicts thereby acquire criminal records, which is what voluntary treatment is designed to avoid.

152. The Lexington Hospital has a capacity of 1300 beds, but has taken as many as 1500 patients at one time. It averages 4000 patients a year. Fort Worth has 1000 beds, but in 1950 only about 250 were used for addicts (the rest of the hospital was devoted to veterans). Women's facilities were limited to 160 beds, with a constant waiting list. Recidivist male applicants often had to wait for admittance. MAYOR'S COMMITTEE, REPORT 27-8; *Hearings, supra* note 16, at 130, 133. This situation was eased by the 1951 addition of 300 beds at Forth Worth. N.Y. Times, March 27, 1951, p. 24, col. 4.

153. The recommended duration of treatment differs from a minimum of 4 months to a maximum of 12 months, with an average of about 6 months. VOGEL, TREATMENT OF THE NARCOTIC ADDICT BY THE U.S. HEALTH SERVICE 4 (1948). After completion of withdrawal and treatment of any medical defects, patients are given occupational assignments on a farm or in a workshop. They are provided with education opportunities and all types of athletics and entertainment. The object is to accustom them to a life without drugs. See VOGEL, OUR YOUTH AND NARCOTICS 6 (1951).

154. See *Crime Committee Hearings* pt. 14, p. 227.

155. "The plan is to send teams of social workers and psychiatrists to [these] cities to maintain contact with former patients and . . . help rebuild their lives." SEN. REP. No. 725, 82d Cong., 1st Sess. 34 (1951). See also GOLDSTEIN, REPORT 107.

156. MAYOR'S COMMITTEE, INTERIM REPORT 9.

possible by association of the younger patients with older addicts or hardened criminals.[157]

Apart from federal facilities, programs and places for treatment of addicts are practically non-existent. According to the Public Health Service, there are few private hospitals equipped to give the necessary treatment. Where they exist, the cost of treatment is prohibitive for the average addict.[158] State programs for treatment are similarly lacking. Some states do provide for the hospitalization of addicts, but treatment beyond withdrawal is negligible.[159] Most states simply imprison addicts. Once the addict is imprisoned, he is abruptly separated from narcotics.[160] After withdrawal he is treated like all other criminals.

Of all the states, only New York has plans for improving its treatment facilities. New York has provided for the non-criminal confinement of addicts under 21 years of age [161] in a recently established hospital on North Brother Island.[162] The treatment program embraces physical withdrawal,

157. For testimony of patients concerning criminal and addictive indoctrination due to non-segregated conditions at Lexington, see GOLDSTEIN, REPORT, 96-7. See also *id.* at 94-6.

158. According to Dr. Vogel, the few private sanatoriums that treat addicts charge from $100 to $200 a week. Hospitalization of at least 4½ to 5 months is necessary. Those addicts who can afford such sanatoriums for only a few weeks invariably relapse. *Crime Committee Hearings* pt. 14, p. 228.

159. Georgia provides for the institutional commitment of addicts. GA. CODE ANN. § 42-818 (1937). New York provides for the confinement of addicts under 21. N.Y. CODE CRIM. PROC. §§ 913(a)-(d). But Dr. Vogel testified that state hospitals are too overcrowded and inadequately financed to take care of addicts properly. *Crime Committee Hearings* pt. 14, p. 228. For example, Bellevue Hospital in New York, in which many teen-age addicts are hospitalized, was not equipped for a rehabilitation program. After withdrawal, patients were sent home, and, according to Dr. Paul Zimmering, Senior Psychiatrist at Bellevue, promptly returned to drugs. GOLDSTEIN, REPORT 100. See also SEN. REP. No. 725, 82d Cong., 1st Sess. 34 (1951).

160. For the "cold turkey" (abrupt withdrawal) treatment in New York prisons, see GOLDSTEIN, REPORT 103. See also note 170 *infra*.

161. The recently passed N.Y. Adolescent Drug Users Law provides for the non-criminal commitment of addicts under 21 to the newly established narcotic hospital on North Brother Island. N.Y. PUB. HEALTH LAW § 439-a. Under the law, a special narcotics court began to function on May 1, 1952. Any interested party may present a petition to this court setting forth information that a youth is an "adolescent narcotics user." The magistrate will then order a hearing in the court and, if necessary, a medical examination. If the magistrate rules that the youth is an addict, he may order him to be admitted to the hospital. The patient must remain there until the superintendent of the hospital informs the magistrate that no further treatment is needed. All proceedings and records of the court are private. And commitment will not be deemed a conviction. N.Y. Times, April 1, 1952, p. 59, col. 1.

162. The hospital opened on May 1, 1952. N.Y. Times, April 1, 1952, p. 59, col. 1. "[Its] facilities [are] immediately available for 150 patients, with expansion planned to 200. . . . The project will have a staff of 306 full-time and 97 part-time employees, in addition to volunteers from social service agencies. The cost of operation will be shared by the state and city." GOLDSTEIN, REPORT 105.

physical rehabilitation, psychotherapy, and occupational therapy during the three-month stay at the hospital, followed by prolonged post-hospitalization care.[163] Aside from New York, most states are apparently looking solely to the Federal Government to provide for treatment of addicts. Several states have already passed laws authorizing judges to commit addicts to the federal hospitals[164]—only congressional approval is necessary to give these laws effect.[165]

Penalizing the Addict

Although addiction is not a federal crime, addicts are subject to the same penalties as criminals who engage in illicit traffic. Because federal statutes make unauthorized possession of narcotics sufficient to convict a defendant,[166] the statutes act to catch any who may hold the drugs regardless of the purpose for which the drugs are held. Representative Boggs, at the introduction of the Boggs Act's severe penalties, justified conviction for possession and thus the conviction of addicts, on the ground that it is impossible to enforce narcotics laws effectively if a legislative distinction is drawn between possession by addicts and possession by peddlers.[167] Sponsors of the Act also pointed out that since the Bureau was interested in peddlers and not addicts, a distinction might be made administratively without impairing enforcement.[168] In fact, however, the Bureau has drawn no administrative distinction. Unavailability of information makes impossible the computation of the precise number of non-peddling or peddling addicts convicted under federal narcotics laws. But the Bureau has itself indicated that non-peddling addicts (and certainly

163. GOLDSTEIN, REPORT 105-6. The hospital will have a school unit, gymnasium, auditorium, and social agencies. The staff is designed to include a senior psychiatrist, four junior psychiatrists, four psychologists, nine psychiatric social workers, seven recreation leaders, and four occupational therapists. At the time of a patient's admittance, agencies make thorough studies of his environment and check each of his associates in an attempt to find others who are using drugs. After discharge from the hospital, the youths are to report and continue to receive regular attention at community clinics, which are to be established in each borough. Their home life will be studied and, if possible, improved. MAYOR'S COMMITTEE, INTERIM REPORT 19-22.

164. See VOGEL, TREATMENT OF THE NARCOTIC ADDICT BY THE U.S. PUBLIC HEALTH SERVICE 7 (1948).

165. See *Crime Committee Hearings* pt. 14, p. 243.

166. See notes 98-102, *supra*.

167. This was the argument of Representative Boggs. N.Y. Times, July 17, 1951, p. 16, col. 4.

168. Representative J. G. Donovan, one of the sponsors of the Boggs Bill, testified before the House Committee holding hearings on the Bill: "[T]his bill is not intended to make a police force of the Narcotics Bureau of the Treasury Department whose task is to apprehend addicts. This is a two-pronged problem, addicts and traffickers. This bill is directed at traffickers. Addiction cure is a local state problem more than it is a federal problem. . . ." *Hearings, supra* note 16, at 55.

addict peddlers) were imprisoned for long terms both before and after passage of the Boggs Act.[169]

Under state law criminal penalties are imposed on addicts. Several states provide for the imprisonment of addicts on grounds that addiction itself is a crime. Here, conviction of the addict may be obtained independent of proof of possession of narcotics.[170] And all states make possession a crime.[171] Penalties for possession, whether for consumptive use by the addict or for peddling, are ordinarily uniformly severe.[172] New York alone attempts to distinguish between non-peddling addicts and peddlers by treating possession either as a felony or misdemeanor, depending upon the quantity of narcotics held by the defendant.[173] Thus, in New York, the addict is still penalized but his punishment may be less severe.

Prevention: Educational Measures

Today, officials are emphasizing education as an effective method of reducing the demand for narcotics and thus of preventing the development and spread of addiction.[174] Generally, the once prevalent theory that education arouses curiosity and thereby spreads the use of narcotics is being thrown into discard.[175] At the federal level, Public Health Service officials have advocated

169. Prior to the passage of the Boggs Act, Mr. G. W. Cunningham, the Deputy Commissioner of Narcotics, testified to the arrest of non-peddling addicts who were sentenced to 3, 4, and 5 years in jail. *Hearings, supra* note 16, at 69. For examples of other addicts, with no history of peddling, imprisoned for possession of narcotics, see *Crime Committee Hearings* pt. 14, pp. 203, 216. The minimum two-year sentence established by the Boggs Act was recently imposed on a person who the Bureau conceded was no peddler but only a user. N.Y. Times, Feb. 7, 1952, p. 15, col. 8. The number of persons arrested by the Bureau on narcotics charges between 1940 and 1950 was 20,936. It seems unlikely that such a large number could have been peddlers. See *Hearings, supra* note 16, at 57.

170. See, *e.g.*, CAL. HEALTH AND SAFETY CODE §§ 11721, 11722 (Deering, 1949) which penalizes the unlawful use of narcotics with 3 to 6 months in the county jail and provides that no probation or suspension of sentence may be granted. See also ORE. LAWS ANN. § 24-636 (Supp. 1947) which punishes habitual users as vagrants.

171. See note 115 *supra*.

172. The UNIFORM NARCOTIC DRUG ACT § 2 (1932) makes no distinction between illegal possession, sale, and manufacture.

173. Possession of less than one quarter of an ounce is a misdemeanor. N.Y. PEN. LAW § 1751 (Supp. 1952). Any person with an amount less than this is unlikely to be a peddler. GOLDSTEIN, REPORT 79.

174. See SEN. REP. No. 725, 82d Cong., 1st Sess. 33-4; GOLDSTEIN, REPORT 109-15; MAYOR'S COMMITTEE, REPORT 53; MAYOR'S COMMITTEE, INTERIM REPORT 25-7.

175. See SEN. REP. No. 725, 82d Cong., 1st Sess. 33 (1951). Dr. Vogel believes that "a sensible, nonsensational, educational program" would be beneficial even though "there would be some individuals of psychopathic nature, or some who, feeble-minded, might have their curiosity aroused." *Crime Committee Hearings* pt. 14, pp. 245-6. See also GOLDSTEIN, REPORT 115. For testimony of addicts that they would not have taken the initial dose if they had realized the consequences, see SEN. REP. No. 725, *supra*; VOGEL, OUR YOUTH AND NARCOTICS 4 (1951).

an educational program against addiction similar to the one waged against venereal disease.[176] And the Senate Crime Committee considered use of television and radio to demonstrate the effect of narcotic addiction.[177] Thus far, however, little has been done. Because of their control over school systems, the states carry the principal burden of pushing a narcotics education program. Here, as well, little has been accomplished. State laws on narcotics education are inadequate or unobserved.[178] Teachers are not properly acquainted with the subject, textbooks are lacking, and consistent educational methods have not been developed.[179] New York, however, is taking some steps to vivify a narcotics education program through the training of teachers[180] and development of teaching methods fitted to the problems and pupils of specific city areas.[181]

Attempts to handle the narcotics problem by attacking the demand for narcotics have been uniformly unsuccessful thus far. The effect of much-talked-about ventures on the educational front can currently be summarily dismissed; for while proposals may be sound, concrete programs have yet to

176. See *Crime Committee Hearings* pt. 14, pp. 244-6; GOLDSTEIN, REPORT 114-15.

177. *Crime Committee Hearings* pt. 14, pp. 28, 50.

178. Invariably, addicts before the Senate Crime Committee testified that they never learned the effects of addiction before contamination. See note 175 *supra*. See also GOLDSTEIN, REPORT 109.

N.Y. EDUC. LAW § 804 provides that three hours a week, ten weeks a year should be devoted to instruction on alcohol and narcotics between the 3d and 10th grades. It also requires teachers to pass a "satisfactory" examination in the subject. The N.Y. Attorney General found that the law was being largely disregarded. GOLDSTEIN, REPORT 109-13. This is not surprising since the statute sets up no exact standards, entrusts enforcement to no competent agency, sets very early age limits, and allows for no differentiation in instruction between slum and other sections.

179. Teachers testified before the N.Y. Attorney General that they would not be able to recognize narcotics. *Id.* at 113. There were no specific textbooks available for New York schools. *Id.* at 111. And many superintendents stated that they had not considered narcotics important enough to teach. *Id.* at 112-13. Dr. Jansen, the Superintendent of Schools in New York City, testified that narcotics were not adequately taught because "until this year people were not aware of the serious situation." *Id.* at 112.

180. In 1951 both the New York Board of Education and the New York police sent educational material to teachers. The Board also issued a brochure on teaching methods and ordered instruction in accordance therewith to be given to students from the 7th to the 12th grades. *Id.* at 112-14. Likewise, in 1949 Illinois introduced an educational program into its high schools. *Crime Committee Hearings* pt. 14, p. 286.

181. The N.Y. Attorney General recommended to the legislature that narcotics education be made the responsibility of a central body, the State Department of Education, and that the Commissioner of Education be "charged with the duty of formulating a program, with sufficient latitude provided for meeting the differing conditions in various parts of the state." GOLDSTEIN, REPORT 114. This recommendation was adopted. N.Y. EDUC. LAW § 804-a.

operate in any considerable degree. Other modes of attack—penalizing the addict and treating him—require a closer scrutiny.

The failure to reduce demand by treating the addict may be traced in part to existing conditions of treatment. It is an understatement to label existing facilities and programs as inadequate. Since states provide almost no facilities at all and state courts may not send addicts to federal hospitals, many addicts never receive treatment.[182] Nor are federal facilities sufficient to handle voluntary patients and addicts convicted in federal courts; many are turned away.[183] But even assuming that the addict does reach a federal hospital, he is still not given the kind of treatment currently recognized as necessary for an attempted cure. There is substantial agreement, for example, that an extensive follow-up program after release is a significant phase of treatment.[184] But it is only recently that the Federal Government has instituted such a program—and in a small degree.[185] Additionally, since roots of addiction frequently stem from personality defects, psychiatric care is obligatory for effective treatment. Yet staffs are woefully weak in psychiatric personnel, and individual attention for the addict is well nigh impossible.[186] At the same time, voluntary patients are allowed to negate their agreement to remain with the hospital until released.[187] This not only throws the addict back into society uncured, but also wastes the money and effort involved in the incomplete treatment he has received.

Even under the most favorable conditions, however, medical science has yet to produce an assured cure for addiction. Federal treatment thus far has produced a low measure of success.[188] Of course, this can hardly be considered conclusive, since methods, facilities, and programs have not been adequate

182. Thus New York alone had 1,649 addicts in its prison population in the first nine months of 1951. GOLDSTEIN, REPORT 16. Most of the petty crimes committed by addicts—such as prostitution, theft, shoplifting—are state, not federal, offenses.

183. See note 152 *supra*.

184. See note 143 *supra*.

185. See notes 154, 155 *supra*.

186. *E.g.*, the psychiatric program at Lexington Hospital. On admittance, each patient receives a complete psychiatric examination. Thereafter, a few selected patients are encouraged to participate in group psychotherapy, where the physicians and the patients attempt to talk out their problems. Other patients are given no psychiatric treatment due to a lack of facilities. *Crime Committee Hearings* pt. 14, p. 149. Dr. Isbell, director of research at Lexington Hospital, testified that patients who have developed a sufficiently high level of emotional maturity before becoming addicted should be offered intensive individualized, not group, psychotherapy. Unfortunately, there are not enough psychiatrists for this. Then again, "many addicts with intense infantile fixations obtain very little benefit from psychotherapy and, in such instances, the best procedure is to provide a short period of intensive institutional supervision followed by a long period of supervision of the patient in his home environment." *Hearings, supra* note 16, at 161-2.

187. See note 151 *supra*.

188. Dr. K. W. Chapman, Assistant Chief, Division of Hospitals, U.S.P.H.S., estimates that not more than 15% of federal patients are cured. GOLDSTEIN, REPORT 94.

and treatment is still in an evolutionary and experimental stage. Nevertheless, the high rate of relapse into the narcotics habit after hospitalization and rehabilitation indicates that present treatment is a gamble at best. Even the most recently developed program—the New York North Brother Island Hospital for youthful addicts—has met with such little success, despite utilization of latest equipment and "know-how," that the New York Commissioner of Hospitals has suggested abandoning the project.[189] While the project is too young to provide definitive evidence pointing to its eventual efficacy, it nevertheless substantiates the conclusion that, currently, highly effective treatment is not available. And even this project will not admit the more confirmed addicts, since successful treatment for these addicts is considered too difficult to warrant undertaking.[190] Generally, the problem of successful treatment and rehabilitation of the addict provides two significant questions as yet unanswered: whether it is medically possible to obtain a cure for addiction in a large proportion of cases; and, if such a cure is possible, whether it is financially feasible to provide the necessary requisites for cure.

Imprisonment of the addict is a total failure as a means of attacking demand. It may be urged that penalties for addicts will deter people from using narcotics. Of course, it is difficult to envision accurately how the threat of punishment operates in initial prevention of resort to narcotics. But one conclusion is obvious: penalties or no, addiction is a thriving practice. And once a drug habit is acquired, the deterrent effect of imprisonment—whether for long or short periods—is negligible; there is every indication that addicts return to narcotics after release from jail.[191] Justification for imprisoning addicts may, however, rest on other grounds. Perhaps the chief reason advanced for imprisonment is that of facilitating an attack on illicit supply: peddlers, it is claimed, will escape conviction unless possession is made a felony.[192] It is true that the sufficiency of proof of possession for conviction does make it easier to cope with illicit supply. But other means are equally available to accomplish this objective. The law can just as effectively punish peddlers if possession is made presumptive evidence not of an illegal purchase, but of an intent to sell. This approach would at least give addicts

189. N.Y. Times, Jan. 24, 1953, p. 11, col. 5, (statement of Dr. Marcus D. Kogel). "During the first six months of its operations the Hospital had 197 admissions involving 173 individuals, twenty-four of whom were admitted more than once. During the first month sixty-nine patients were admitted, but in the same period as many as fifty left the hospital, either 'absconding' or being discharged because they were found to be unsuitable for the hospital's program." Dr. Kogel stated that many patients had sought admission "to kick the habit to a cheaper level" (they wanted just enough of a cure to be able to achieve narcotic gratification through smaller and less expensive doses). *Ibid.*

190. *Ibid.*

191. See GOLDSTEIN, REPORT 103; MAYOR'S COMMITTEE, REPORT 45-6.

192. This is the argument of Representative Boggs, who sponsored the Boggs Act. N.Y. Times, July 17, 1951, p. 16, col. 4. For a similar argument by the New York City Mayor's Committee, see MAYOR'S COMMITTEE, REPORT 44-5.

an opportunity to convince a jury that they were not peddlers. Another possibility—suggested by New York law [193]—is to make possession of a minimum amount necessary for conviction. Possession of an amount large enough for the use of only one addict is unlikely to indicate a peddler.[194] Since other means are available to separate peddlers from addicts without impairing enforcement, and since imprisonment does the addict no good, it seems senseless to subject the addict to harsh criminal penalties on grounds of facilitating enforcement.

Imprisoning the addict does, however, serve to remove him from society and thus prevents his criminal activity either in peddling or other illegal pursuits made necessary by his insistence on acquisition of narcotics. In practice, this may actually comprise the real basis for incarceration. Hospitalization, it is true, is a more constructive and humane approach. At least it affords some opportunity of making the addict a socially useful individual while it confines his activities at the same time. But whether through lack of interest, lack of funds, or lack of faith in the possibility of cure, states have simply not provided for hospitalization. They are thus faced with the serious dilemma of imprisoning the addict who engages in criminal activity or of letting him roam free to continue his illegal pursuits. And while imprisonment does nothing constructive for the addict it can conceivably be justified as a socially protective device *in the absence of any other alternative*. The difficulty with this device, however, is that imprisonment for any term short of life will not keep the addict effectively out of circulation, since once out of prison he will again return to his habit. The dilemma does not rest with state programs alone, but rather pervades the entire narcotics problem. As long as hospitalization and rehabilitation do not produce effective cures, addicts will remain addicts and their habits may drive them to illegal activities.

The problem of dealing with the addict, then, affords no easy solution; and the ambivalent approach of treatment and/or imprisonment is readily explainable. It is of course desirable to take every step to cure the addict. And it is to be hoped that unsparing effort will be devoted towards developing facilities and methods of treatment. Yet it must be realized that, at this juncture, treatment is incapable of effectively coping with demand, and that imprisonment for the sake of deterring resort to drugs is even more fruitless an attack on demand. Nevertheless, imprisonment, as harsh and inhumane as it may seem, will apparently be resorted to for other reasons either where cure cannot be attempted or where cure, once attempted, has failed. In the light of the current failure of treatment, and the unsatisfactory solution provided by imprisonment, it is surprising that authorities have not inspected other measures, at least as a stop-gap device, to cope with the narcotics problem.

193. See GOLDSTEIN, REPORT 77-81; MAYOR'S COMMITTEE, INTERIM REPORT 10; note 138 *supra*.

194. GOLDSTEIN, REPORT 79.

THE CLINIC SYSTEM

Between 1912 and 1920, an attempt was made to solve the narcotics problem by "legalizing" addiction through a "clinic system." Starting with Jacksonville in 1912, over 40 cities throughout the country established clinics which legally dispensed narcotics to addicts.[195] While most clinics engaged solely in dispensing drugs, others also attempted to give treatment to certain narcotics users selected as being not too seriously addicted and thus potentially "curable."[196] Generally, the objectives of the clinics were the same: to prevent illicit traffic and spread of addiction, to relieve suffering, and to keep addicts out of jail and free of criminal activity.[197]

Dispensation of narcotics was guarded to prevent abuse of the system. Most clinics kept the drugs entirely within their control. They dispensed drugs directly rather than through prescriptions.[198] And in some clinics dispensation was only to addicts registered with the clinic.[199] To prevent resale of the drugs by the addict, some clinics required patients to sign pledges that they would not resell,[200] while other clinics adopted an apparently more effective device of administering only enough drugs to satisfy the patients. At the same time, steps were taken to prevent social degeneration of the addict. Some clinics demanded that addicts obtain jobs as a prerequisite to procuring narcotics. Then doses were ordinarily kept at a minimum consistent with comfort in order to keep addicts job-worthy.[201] To prevent resort to crime and patronage of peddlers rather than clinics, prices charged for dispensation were based on medical cost—far below illicit market price.[202] And records of patients provided a constant check militating against criminal activity and

195. See TERRY & PELLENS, THE OPIUM PROBLEM 849 (1928). For a listing of cities with clinics, see *id.* at 876.

196. *Id.* at 846, 849 (dispensation), 865, 872 (dispensation and treatment).

197. *Id.* at 845, 849, 868-9, 872.

198. The Jacksonville clinic was one of the few to issue prescriptions. *Id.* at 849, 866, 872-3.

199. Thus in the New York clinic every addict was required to be registered and had to report every day for his dose of narcotics, which was intentionally kept small. *Id.* at 842-3.

200. *Id.* at 867.

201. *Id.* at 866, 873. The medical director of the Los Angeles clinic, however, stated that the dosage must not fall so low as to induce addicts to revert to illicit purchases. *Id.* at 873. The Shreveport clinic demanded that all patients who were not infirm or bed-ridden work and secure proper food and clothing. *Id.* at 867. Similarly, the Los Angeles clinic reported that many of its patients were following useful occupations. *Id.* at 892. The medical director of the New Orleans clinic reported: "We have made economic assets of many who formerly were human derelicts . . . by enabling [them] to keep honestly employed." *Id.* at 846.

202. At the Jacksonville clinic addicts bought morphine at only 1 cent a grain. *Id.* at 849. At the Los Angeles clinic the price was 10 cents, while peddlers charged from $1 to $2.50. *Id.* at 874, 892. The Shreveport clinic charged 6 cents as opposed to a peddler's price of $1.00. *Id.* at 867. The difference between the drugs' cost to the clinic and what the addict paid went for operating expenses. *Ibid.*

patronage of peddlers in addition to the clinic.[203] The requirement that addicts be job-worthy accomplished the same goal, since addicts on constantly increased doses could probably not meet the requirement.[204]

The "clinic system" afforded limited success in coping with some of the problems of narcotic addiction. Drugs were sold at a price illicit traffickers could not meet. At the same time, the law was strictly enforced against peddlers. As a result, Jacksonville and other cities reported the speedy disappearance of peddlers.[205] Additionally, the low price of narcotics apparently rendered unnecessary criminal activity on the part of addicts.[206] This, in turn, also strengthened the attack against illicit traffic. Penalties could be imposed on peddlers without fear of increasing the price of narcotics and therefore crimes by addicts, and addicts patronizing the clinics no longer constituted a reservoir of potential peddlers driven to the practice by the need for drugs. Likewise, there was no incentive for peddlers to recruit new addicts, for they would lose their new customers to the clinics.[207] The effect of the "clinic system" on the addicts themselves is evidenced by the fate of the addict on the closing of the "clinic system." When the Shreveport, Louisiana, clinic was closed, records were kept of the subsequent activities of over one hundred former patients: a large number went to jail; the rest were forced to patronize peddlers.[208]

Any evaluation of the "clinic system," however, must be tempered by acknowledgment that factual material is sparse. Only limited reports are available, and these were authored by clinic administrators, parties most interested in shedding favorable light on the clinics. In any event, the clinics were closed in the 1920's when the Federal Government insisted that they contra-

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203. The medical directors of the New Orleans and Shreveport clinics reported reduction in criminal activity and the rehabilitation of addicts. In addition, the director of the New Orleans clinic stated: "All addicts are known and if any are 'wrong-doers,' they are apprehended. This instils a fear of crime and results in good behavior." TERRY & PELLENS, THE OPIUM PROBLEM 846, 868 (1928).

204. *Crime Committee Hearings* pt. 14, p. 124.

205. While the Jacksonville dispensary was in operation—1912-14—illegal selling was reportedly confined to one or two peddlers supplying certain customers who preferred to pay the extra price rather than incur the inconvenience of going to the clinic. Immediately upon the discontinuance of the dispensary, a large illicit traffic arose and prices soared. TERRY & PELLENS, THE OPIUM PROBLEM 849-50 (1928). The medical directors of the New Orleans and Shreveport clinics reported similar experiences. *Id.* at 844, 869-70.

206. See notes 202, 203 *supra*.

207. Thus, according to the testimony of peddlers before the Senate Crime Committee, the practice today is to entice new customers by giving doses of heroin free until dependence is achieved. SEN. REP. No. 725, 82d Cong., 1st Sess. 24 (1951). Under the clinic system the peddler loses dependent customers to the dispensary. The incentive to recruitment thus disappears and the peddler is unable to survive. See note 205 *supra*.

208. TERRY & PELLENS, THE OPIUM PROBLEM 870 (1928). Likewise, after the closing of the Los Angeles clinic, its director reported that many former patients broke with their families and lost their jobs. *Id.* at 875.

vened the Harrison Act.[209] Currently, the "clinic system" stands in ill repute insofar as Public Health Service officials are concerned. Their objections are primarily two: that such clinics are incompatible with effective medical treatment and prevention of addiction; and that clinic patients would seek constantly increased doses and would spread addiction.[210]

Contrary to the claim of the Public Health Service, there is little justification for asserting that clinics spread addiction. Clinics usually dispensed drugs only to chronic addicts. Effective administration of a "clinic system" could conceivably assure that this practice continued and could also assure that there is no diversion of drugs to new users. Thus new users would have to obtain drugs through peddlers. But new narcotics users are not generally willing to pay the high price demanded by peddlers. And the peddler's practice of giving free doses initially to encourage a permanent buyer would be ineffectual under a "clinic system." Free doses are given only on expectation of a profitable return, and such ultimate profit would be unlikely, since the peddler, unable to compete with clinic prices, would lose his customers to the clinic. The Public Health Service's claim of spreading addiction does have some validity, however, in the sense that addicts may require increased doses. To some extent, this possibility can be controlled by the requirement that patients be gainfully employed—a requirement that addicts on increased doses cannot meet. But even if increased doses were demanded, it would seem better that clinics, rather than peddlers, dispense them. Addicts, insofar as they cannot be limited by clinics, would seek increased doses anyway. At least dispensation through clinics prevents the nourishment of illicit traffic. And, most important, it prevents the major consequence of illicit traffic: the addict's resort to crime.

The Public Health Service's objection that clinics are incompatible with effective medical treatment is true, but unrealistic in the current state of the narcotics problem. Of course, so long as drugs are dispensed, narcotic habits will continue and cures cannot be effected for "dispensees." However, the Service's objection is a Utopian rather than pragmatic one. It ignores the fact that many—if not most—addicts never receive treatment. And it further fails to realize that treatment is hardly "effective" in the current state of its development. While insistence on improved facilities and treatment methods is eminently desirable it does nothing in the immediate future to alter the narcotics problem substantially. Indeed, there is no assurance that effective methods and facilities can ever be devised to operate on a large scale.

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209. The last clinic was closed at Shreveport, La., in 1923.

210. For the views of Public Health Service officials, see *Crime Committee Hearings* pt. 14, p. 228; VOGEL, ISBELL, & CHAPMAN, PRESENT STATUS OF NARCOTIC ADDICTION 21-2 (1948).

The "clinic system," however, has its adherents among doctors. The Richmond County Medical Society recently proposed providing clinics for the cheap dispensation of narcotics as a measure "to combat crime among narcotics addicts." N.Y. Times, March 6, 1953, p. 14, col. 3.

The "clinic system," on the other hand, presents an immediate *modus operandi* to attack illicit traffic.

The "clinic system" attacks the crux of illicit traffic: its profit. Clinics can dispense drugs at a cost which no illicit trafficker can meet, or at a cost which can be met only at the sacrifice of profit. Since the trafficker does not engage in criminal activity for play, when profits are wiped out, the criminal venture is no longer worth the risk. If the law is strictly enforced against the illicit trafficker at the same time—as was apparently done under the original "clinic system"—logic dictates the same conclusion suggested by the possibly colored reports of the original clinics' operations: illicit traffic should disappear speedily. With its disappearance the serious social consequences of addiction should vanish as well: the addict's criminal activity, his social irresponsibility, and the peddler's recruitment of new addicts. Of course, the "clinic system" does not eliminate the narcotic problem—it does not seek to.

At best, the "clinic system" is a stop-gap measure which may curtail narcotics problems until means of curing addicts are devised. And, at the same time, possibilities of treatment through the cooperation of clinics and hospitals actually promote utilization of whatever virtues current treatment may offer. In the light of the general failure of controls aimed at eliminating illicit traffic and the ineffectual or inhumane attempts to handle addicts, a return to the "clinic system" seems highly desirable.